HEALTH INSURANCE OPTIONS: PROPOSALS FROM THE PROVIDER COMMUNITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JULY 24, 1990

Serial 101-106

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

33-773 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J.J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD FORD, Tennessee
ED JENKINS, Georgia
THOMAS J. DOWNEY, New York
FRANK J. GUARINI, New Jersey
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
ROBERT T. MATSUI, California
BERYL ANTHONY, JR., Arkansas
RONNIE G. FLIPPO, Alabama
BYRON L. DORGAN, North Dakota
BARBARA B. KENNELLY, Connecticut
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
MICHAEL A. ANDREWS, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin
BENJAMIN L. CARDIN, Maryland

BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
DICK SCHULZE, Pennsylvania
BILL GRADISON, Ohio
WILLIAM M. THOMAS, California
RAYMOND J. McGRATH, New York
HANK BROWN, Colorado
ROD CHANDLER, Washington
E. CLAY SHAW, JR., Florida
DON SUNDQUIST, Tennessee
NANCY L. JOHNSON, Connecticut

ROBERT J. LEONARD, *Chief Counsel and Staff Director*
PHILLIP D. MOSELEY, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, California, *Chairman*

BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
J.J. PICKLE, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin
BENJAMIN L. CARDIN, Maryland

BILL GRADISON, Ohio
ROD CHANDLER, Washington
PHILIP M. CRANE, Illinois
NANCY L. JOHNSON, Connecticut

CONTENTS

HEALTH INSURANCE OPTIONS: PROPOSALS FROM THE PROVIDER COMMUNITY

TUESDAY, JULY 24, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:08 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, JULY 18, 1990

PRESS RELEASE #34
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON HEALTH INSURANCE OPTIONS:
PROPOSALS FROM THE PROVIDER COMMUNITY

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health insurance options: proposals from the provider community. The hearing will be held on Tuesday, July 24, 1990, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

This will be the sixth hearing in this Congress in the Subcommittee's ongoing investigation of options for universal health insurance coverage.

The hearing will focus on options for coverage developed by the American College of Physicians and those developed or under development by other providers, including the American Hospital Association, the Catholic Health Association, and the National Association of Public Hospitals.

The recommendations of the American College of Physicians focus on a set of principles for reforming the health care system. Among other recommendations, the College concluded that a nationwide program is needed to assure access; that all persons should have health insurance; and that expansions of Medicaid and mandated employer health insurance require immediate consideration for bringing relief to those without insurance. For the longer term, the College concluded that alternative approaches must be explored, including a unified national insurance mechanism.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, August 9, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good morning. The Health Subcommittee of the Committee on Ways and Means will continue hearings on health insurance with a discussion of options for broad health insurance coverage developed, or in the process of being developed, by the provider community.

Today, we will focus on options to be put forth in a position paper of the American College of Physicians and those developed or under development by other providers, including the American Hospital Association, the Catholic Health Association, and the National Association of Public Hospitals.

The recommendations of the American College of Physicians focus on a set of principles for reforming the health care system. Among other recommendations, the college concludes that:

A national program is needed to assure access; all persons should have health insurance; expansions of Medicaid and mandated employer health insurance require immediate consideration for bringing relief to those without insurance; and, for the long term, the college concludes that alternative approaches must be explored, including a unified national insurance mechanism.

I am pleased that the provider organizations are taking the lead in developing proposals to provide health insurance for every American. There is no organized constituency specifically representing the uninsured, and yesterday, Health and Human Services disavowed any responsibility for that, suggesting that private enterprise should do it.

So much for Health and Human Services in this administration taking any significant role in that area. Therefore, other organizations will have to take the lead if we are to have any progress on this issue.

Efforts on the part of provider organizations to respond to this problem represent enlightened self-interest of the best type. We are all aware that the increase of bad debt, charity care, and uncompensated care puts a difficult burden on hospitals who try to do the right thing, and that is most hospitals.

In 1985, hospitals provided about $7.5 billion in uncompensated care. I hasten to add this isn't necessarily charitable care, it is just uncompensated. This is a difficult burden. Public hospitals, which have only 21 percent of the hospital beds, are providing more than half of all the charity care.

Also, provider efforts to close the gap in the health insurance safety net are more useful and helpful than carping about current reimbursement levels, and I am glad to see them. If, in fact, hospitals had no one coming to the doors who was not able to pay under a health insurance scheme, I suspect that the level of the Medicare reimbursement payments would become less significant.

On July 18, I introduced H.R. 5300. I call it the MediPlan Act of 1990, and it is obviously a discussion piece.

The concept is that it will provide comprehensive health and long-term care coverage to every—and I underline every—resident in the United States. It provides a method whereby this care can be financed in a progressive way, so that 1 percent of the Americans, who now have more assets than 100 percent of the lower-income Americans, will pay slightly more than the impoverished Americans for their health care.

A number of alternative approaches include many ideas that we are going to hear about today. To those who support these alternatives, all I ask is that their plan meet these two requirements:

That we assure comprehensive coverage, and that we spell out how we are going to pay for it. Who is going to pay, and exactly how much is critical. Many of us on this committee remember the days of catastrophic health care coverage for Medicare. Those short, wonderful days of yore.

One of the problems is that there was confusion and lack of understanding about just who was going to pay how much for which benefits. I don't think we can let that happen again.

So, as we now know, 75 percent of Americans want health insurance or say they want national health insurance; we also know that most of them don't have any realistic understanding of what that might cost them as individuals, or how the cost might be transferred to a variety of payers.

I welcome today's witnesses. I hope we can have a spirited discussion. I hope we can have alternative suggestions. And for those who do not yet have a complete plan, I hope I can get a commitment from the witnesses to say when they come back to us with the plans that they are perfecting, they will be able to meet the twin test, coverage for each resident in our country for what we could all agree is a minimum health care insurance package; and, second, a means to pay for it, recognizing that in one way or another, we are already paying for it, but we are placing very unfair burdens on various segments of society.

[The opening statement of Chairman Stark follows:]

OPENING STATEMENT OF HON. PETE STARK

Today the subcommittee continues its series of hearings on health insurance with a discussion of options for universal health insurance coverage developed, or in the process of development, by the provider community.

Today we will focus on options put forth in a position paper of the American College of Physicians and those developed or under development by other providers, including the American Hospital Association, the Catholic Health Association, and the National Association of Public Hospitals.

The recommendations of the American College of Physicians focus on a set of principles for reforming the health care system. Among other recommendations, the college concludes that:

A nationwide program is needed to assure access;

All persons should have health insurance;

Expansions of Medicaid and mandated employer health insurance require immediate consideration for bringing relief to those without insurance.

For the longer term, the ACP concludes that alternative approaches must be explored, including a unified national insurance mechanism.

I am pleased that provider organizations are taking the lead in developing proposals to provide health insurance coverage for every American. Certainly, there is no organized constituency specifically representing the uninsured; therefore, other organizations will have to take the lead if we are to make progress on this issue.

Vigorous effort on the part of provider organizations to respond to this problem represents enlightened self-interest of the best sort. We are all aware that the increase in bad debt and charity care is putting a difficult burden on the backs of those hospitals which try to step in and shoulder the load. In 1985, hospitals provided $7.4 billion in uncompensated care. This is a difficult burden for public hospitals which have only about 21 percent of hospital beds, but provide 55 percent of all charity care.

I would also say that provider efforts to find ways to close the gaps in the health insurance safety net are clearly more useful, and helpful, than carping about cur-

rent reimbursement levels, and I am glad to see them. We will certainly take the proposals from the provider community seriously.

On July 18 I introduced H.R. 5300, the MediPlan Act of 1990, to provide comprehensive health and long-term care coverage to every resident of the United States. MediPlan represents my effort to respond to the need to reform the health care financing system.

MediPlan is a comprehensive response to the problem of assuring health benefits to every American. It also includes the necessary revenue to finance the coverage it provides. It is, therefore, a complete plan in response to the challenge we face.

A number of alternative approaches include ideas about which we will hear today, are on the table. To those who support these alternatives, I would ask whether their plan can meet the twin tests of assuring comprehensive coverage while spelling out explicitly how the plan will be financed.

In my view, consideration of any plan which cannot meet these two tests would not be responsible. For this reason, I challenge those who are putting forth ideas today, as well as others who may do so in the future, to set forth how their ideas meet the two tests of comprehensive coverage and explicit financing. Doing so is the best way to push ahead on providing health care coverage to all.

I wish to thank each of our witnesses for appearing here today. I look forward to hearing from our witnesses on this important topic.

Chairman STARK. First of all, I would like to apologize in absentia for my Republican colleagues who had an emergency call to meet with Ambassador Hills. I would like to leave the record open for a wide-ranging amount of partisan comments, to rebut the comments which the Chair does not like to make in the absence of the minority.

Our first witness is Dr. Norton J. Greenberger, who is the present chairman of the department of medicine, of the University of Kansas Medical Center in Kansas City, Kans. He is accompanied by Ms. Deborah Prout, director of public policy for the American College of Physicians.

Doctor, welcome to the committee. I hope in your testimony you will tell us a little bit about the American College of Physicians. We have your prepared testimony in its entirety, and it will, without objection, appear in the record. If you would like to expand on it or summarize it, or engage the committee in dialog as you run through your testimony, we would be happy to do that.

Please proceed in any manner you are comfortable.

STATEMENT OF NORTON J. GREENBERGER, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, AND PROFESSOR AND CHAIRMAN, DEPARTMENT OF MEDICINE, UNIVERSITY OF KANSAS MEDICAL CENTER, KANSAS CITY, KANS., ACCOMPANIED BY DEBORAH M. PROUT, DIRECTOR, PUBLIC POLICY, AMERICAN COLLEGE OF PHYSICIANS

Dr. GREENBERGER. Mr. Chairman and members of the subcommittee, the American College of Physicians, the ACP, appreciates this opportunity to appear before you today to discuss the ACP position on access to health care.

The American College of Physicians was founded in 1915 to foster high standards in the practice of internal medicine. Today, the college is a national medical organization representing approximately 70,000 physicians practicing internal medicine and its specialities.

This spring, the college launched a major access to care project that includes a position statement on the subject, and the formation of a network of over 4,000 ACP members around the country.

Simply stated, ACP's basic conclusion is our health care system has significant problems and requires systematic change. It is not serving the uninsured, nor is it serving insured patients, physicians, employers, or Government.

Our recommendations address not only access to health care, but also the cost of health care, quality of care, medical liability, administrative burdens, and availability of health care facilities and personnel. All of these factors are interrelated.

The college concludes that nothing short of universal access to a level of basic health care will be fair in the long run, and that the time has come for a thoughtful reexamination of all aspects of the health care system.

The college has developed a set of 16 criteria to evaluate proposals for achieving a better health care system. I will briefly summarize these criteria, the details of which are spelled out in my written statement.

Regarding benefits: One, there should be a mechanism for determining the scope of benefits. Two, there should be uniform benefits. Three, coverage decisions should be based on clinical effectiveness. Four, coverage and benefits should be continuous and independent of place of residence or employment.

With regard to financing: Financing should be adequate to eliminate financial barriers to determine needed care. There should be mechanisms for controlling costs. Administrative expenses and procedures should be minimized. Professional liability costs should be minimized. Existing sources of revenue should be incorporated into any new financing system.

With regard to organization and delivery, there should be sufficient infrastructure in terms of both facilities and manpower to deliver health care services efficiently and effectively. There should be mechanisms to assure quality.

Innovation and improvement should be fostered. The system should be flexible. Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive health care, and pursue health promotion activities.

And, finally, patients should be satisfied and physicians and other health care professionals should be satisfied.

The three items that distinguish ACP proposals from other medical organizations are: One, we stress the need for systemic reform; two, coverage could be continuous and transferable; and, three, nationwide financing mechanisms need to be considered.

In this time of crisis in our system, we believe all options should be on the table for discussion. In the position document published on May 1, we analyzed six major types of proposals that use insurance mechanisms for expanding access. These can be listed as follows:

One, encourage individuals and employers to purchase private insurance. Two, mandate employer coverage. Three, create health insurance risk pools. Four, extend and expand Medicaid eligibility. Five, expand charity care. Six, establish a universal access to health insurance program.

Detailed commentary is contained in our full position statement. However, special relevance to the ongoing congressional debate over proposals for mandating employer health insurance, expand-

ing Medicaid, establishing universal access to health insurance program. Our initial thinking on these alternatives, I would now like to comment about.

With regard to mandating employer coverage: Requiring all employers to provide a certain package of health insurance benefits could extend insurance coverage rapidly to approximately two-thirds of the uninsured population, and it certainly warrants consideration as a partial, short-term solution.

However, it would increase cost to employers substantially, increase cost of goods and services, make our products less competitive, and undermine the collective-bargaining process.

Most importantly, employers would still have to purchase coverage in the insurance marketplace, and, therefore, would have no handle on controlling costs. What about extending Medicaid eligibility? Expanding Medicaid eligibility might be a desirable short-term means for improving financial access to health care services for those who are poor or nearly poor, but do not qualify for public assistance.

In addition, expansion would also correct some of the present inequities in coverage and benefits. These improvements would require substantially greater amounts of Federal and State funding, amounts that would be difficult to achieve at a time of budgetary constraints.

Further, the social welfare nature of the program has not engendered public support, and the low payment rates have restricted access to care. Finally, the administrative burdens of Medicaid would need to be addressed in a substantial way.

Establishing a universal access to health care program: Universal access program could be provided through either the public or private sectors, or by some combination of both. The primary advantage of universal access program is everyone is covered, and coverage is continuous, regardless of change in place of residence or employment. All participants have access to mainstream health care.

Such programs in other countries have administrative costs that are much less than those borne in the United States, primarily because there is much less administrative overhead involved in the billing, processing, and collection of claims.

Disadvantages include the potential for greater Government intervention in the practice of medicine and in clinical decision-making, loss of physician ability to set fees for increased pressure for cost containment, and more overt rationing of health care services.

In conclusion, as the college urges comprehensive reform, it cautions against stitching together a patchwork of programs that will not meet long-term needs. Short-term approaches should be in accord with long-term needs. We maintain that universal access to health care is absolutely essential, that no potential solution should be eliminated from full analysis and discussion.

I thank you for your attention. I would be pleased to answer any questions.

[The statement of Dr. Greenberger follows:]

STATEMENT OF
THE AMERICAN COLLEGE OF PHYSICIANS
BEFORE THE
HEALTH SUBCOMMITTEE
WAYS AND MEANS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES
July 24, 1990

Mr. Chairman and Members of the Subcommittee:

The American College of Physicians (ACP) appreciates this opportunity to appear before you today to discuss the ACP position on Access to Health Care. ACP was founded in 1915 to foster high standards in the practice of internal medicine; today the College is a national medical organization representing approximately 70,000 physicians practicing internal medicine and its subspecialties, including gastroenterology, endocrinology, oncology, and cardiology. It includes practitioners providing primary care, medical subspecialists, and medical researchers and teachers.

I am Norton J. Greenberger, MD, FACP, Professor and Chairman of the Department of Medicine at the University of Kansas Medical Center and a practicing physician; accompanying me is Deborah Prout, Director of Public Policy. Coinciding with my election as President of the American College of Physicians this spring, the College launched a major "Access to Care Project" that includes a position statement on the subject and the formation of a network of over 4,000 ACP members around the country to identify local problems and make recommendations for improving the health care system. In the few short months since the ACP position statement was published in the Annals of Internal Medicine, thousands of physicians have indicated their desire to help develop solutions to the problems of our troubled health care system.

Simply stated, ACP's basic conclusion is that our health care system has significant problems and requires systemic change. It is not serving the uninsured, nor is it serving insured patients, physicians, employers, or government. We must work for a comprehensive and coordinated nation-wide program. Our recommendations address not only access to health care but also the cost of health care, quality of care, medical liability, administrative burdens and availability of health care facilities and personnel. All of these factors are interrelated. The College concludes "that nothing short of universal access to a level of basic health care will be fair in the long run," and "that the time has come for a thoughtful re-examination of all aspects of the health care system."

The present state of our health care system lends a new urgency to the task of addressing and resolving problems facing the system. In particular, we are deeply troubled by the large numbers of Americans without adequate access to health care services; inordinate increases in health care costs, including the costs of marketing, health insurance, and malpractice insurance; cost containment actions that undermine the basic infrastructure, including facilities and personnel on which delivery of services depends; and growing administrative burdens and increasing intrusion into the practice of medicine by government and other third-party payers.

Growing pressures from government and business to contain health care costs have resulted in restrictions on the provision of health care services and have eroded physicians' ability to provide patient care. Medicine is suffering from the paradox of being clinically able, but financially unable, to fulfill its mission of caring for those in need. Not only are these factors a source of frustration and demoralization to physicians, they threaten our self-definition as a caring and humane society. It is overwhelmingly clear that more vigorous efforts must be made to address these and related problems.

BACKGROUND

The College's statement on "Access to Health Care" was the result of a two-year process involving the policy committees of the College, the

Board of Governors, the Board of Regents, and members attending presentations at our Annual Sessions and chapter regional meetings. But, we view this position statement as only the initial step in what will be necessary to bring true reform to our health care system. It is a means of disseminating information about the difficult and complex health care access problem, outlining possible approaches for resolving this problem, and urging the full participation of all concerned in developing and implementing solutions. Within our own organization, through our Access to Care Project, we intend to involve as many individual members as possible in collecting further data and developing additional recommendations. Ultimately, we believe that viable solutions will only be developed when all concerned parties sit down and work together, including providers, employers, citizens, and government.

It is important to note that the process that led to the College's position -- the building of consensus for the idea of fundamental reform of the health care system -- taught those of us who were involved some important lessons. Many of us held views that were changed as we continued to review the facts and figures on the access problem and to consider proposed alternatives. Some proposals that appeared at first analysis as sufficient solutions to the problem of access to care, especially the expansion of Medicaid and the mandating of employer health insurance, lost their attractiveness under sustained scrutiny. It became clear that the problems of the uninsured were inextricably linked to the problems experienced by those who already had access to the system. In short, that this is not only the problem of the uninsured but that the present system is not serving insured individuals, physicians, employers or government as well as it should and as well as it could with certain changes.

Therefore, we came to the conclusion that the problems facing this nation with respect to: cost containment, appropriate utilization control, malpractice, determination of societal priorities, improvement of quality, and the maintenance of an appropriate infrastructure, were essential elements of the current access problem. More importantly, even if we "solve" the access problem by insuring all Americans, if we fail to address these interrelated issues we will have developed a short-term fix, not a long-term solution.

We fear that absent comprehensive reform of the system, all of us will continue to be burdened by aggregate costs that are out of control, by administrative costs that are a misuse of potential patient care resources and by administrative burdens that are a source of frustration to patients and providers.

CRITERIA FOR A BETTER SYSTEM

In our policy documents we provided a detailed analysis of the major problems of the current, patchwork, health care system in the United States, including: inadequate financial access, absent or insufficient insurance protection, continually rising costs, and a system that is burdensome for patients, their families, and physicians. We then attempted to outline the characteristics of a more ideal system. The criteria listed below are useful for assessing proposed solutions. They may require further refinement, and they are listed categorically, not in order of priority.

BENEFITS

1. There should be a mechanism for determining scope of benefits.

   An effective health care system should have a rational basis for determining the scope of benefits that are covered and for prioritizing these benefits. The system may not be able to accommodate financially the clinical capacity to provide all possible services.

   Our policy committees have struggled in an effort to develop a definition of an appropriate package of benefits, including whether such benefits should be defined as "basic" or "essential" health services. Despite these efforts and the efforts of those of our members who responded to our surveys, there is little that does not seem to be, in some way or under some circumstances, either basic or essen-

tial. The central challenge, therefore, is how best to select and prioritize the vast array of services which could be made available. There need to be clearly defined roles for both clinical recommendations and priority setting and for a separate process to determine what is financially and practically feasible.

The medical profession must be actively involved in determining clinical appropriateness and effectiveness. However, the process for clinically-based recommendations on services should be kept separate from but be fully informed by the necessarily societal and political determination of what is feasible. In this way, all citizens can be more fully involved in this debate, thereby raising public awareness of the complex problem of appropriate allocation of societal resources. Any decisions to curtail or limit coverage based on costs or budgetary considerations should be made with full representation of all concerned parties, including patients and physicians.

2. There should be uniform, minimum benefits.

There should be a uniform, minimum package of health care benefits for all. These minimum benefits should be "universal," that is, available to everyone. Coverage must not vary geographically as it does presently among both public and private insurance plans because of different judgments among carriers as to what is and is not appropriate. For example, coverage now varies widely among private plans for such services as cosmetic surgery, home health care, psychiatric services, and preventive health care.

Even under the Medicare program, although uniform guidelines and criteria for making coverage determinations are provided to all contractors, each of the 48 carriers, 57 intermediaries, and 54 professional review organizations (PROs) has discretion in making its own coverage decisions. If a national coverage policy decision has been issued concerning a particular item or service, all Medicare contractors are bound by it. If there is no national policy, each contractor makes its own determination. The inequities of this highly decentralized process become most apparent to beneficiaries who on moving from one state to another, find that the services that had been reimbursable by their previous Medicare contractor are not covered by their new carrier.

Physicians dealing with more than one Medicare contractor and with multiple insurance companies are faced with conflicting coverage policies. These conflicts add to their administrative burdens and necessitate additional documentation and paperwork to process claims that may be denied or subjected to various review processes. Lack of a uniform minimum coverage policy is perplexing to both patients and physicians and results in inequitable access to some health care services.

3. Coverage decisions should be based on clinical effectiveness.

An ideal health care system would provide insurance coverage and payment for appropriate and efficacious health care services but would not cover services that are inappropriate, ineffective, or unnecessary. Currently, there is a lack of clinical data on the effectiveness of many medical tests and procedures and a lack of scientific knowledge of what constitutes appropriate care for specific patient conditions or problems. Much research has been done to evaluate new medical practices and technologies. Examples include the ACP Clinical Efficacy Assessment Project, the Patient Outcome Assessment projects supported by the National Center for Health Services Research and Health Care Technology Assessment, the randomized controlled clinical trials sponsored by the National Institutes of Health, and research by the Office of Technology Assessment, the Health Care Financing Administration, and others. However, the total amount of this research, generally known as health services research, has been minuscule in relation to national health care expenditures. Scientific knowledge on effectiveness and appropriateness is still very limited. Consequently, public and private health insurance plans make coverage decisions based on limited scientific

data, determinations of existing norms of care, patient demand, and political and economic considerations.

Ideally, all new -- as well as existing -- medical tests, procedures, and technologies should be evaluated scientifically to determine their clinical efficacy and appropriate conditions of usage. Procedures that are determined to be ineffective or inappropriate should not be covered. Research priorities will need to be set, and coverage decisions reviewed as scientifically sound data become available. The Institute of Medicine, the National Leadership Commission on Health Care, and the Physician Payment Review Commission have recommended that several hundred million dollars in additional federal funding will be needed each year to expand clinical effectiveness research. The College has strongly supported legislative efforts to increase the level of health services research funding.

4. Coverage and benefits should be continuous and independent of place of residence or employment.

Participants should continue to have access to covered health care services regardless of place of residence or employment status. Coverage should be "portable"; persons changing jobs or moving from one state to another should not lose their health care benefits.

FINANCING

5. Financing should be adequate to eliminate financial barriers to obtaining needed care.

The financial burden for the program should be shared progressively. Any premiums, copayments, deductibles, or taxes used to finance it should be based on ability to pay.

6. There should be mechanisms for controlling costs.

Cost containment measures are essential to any health care financing system. Payments should be made only for necessary and appropriate care. There should be incentives for patients to obtain and for health care providers to deliver health care services in a cost-effective manner. Charges and payments for health care services should be based on objective determinations of reasonableness.

7. Administrative expenses and procedures should be minimized.

Administrative burdens on patients, physicians, hospitals, and other health care providers should be kept to a minimum. Requirements for billing and completion and processing of forms and other paperwork should not deter health care professionals from working within the system. Providers of health care should not be subjected to complicated and differing rules and requirements from a multitude of insurers and other third-party payers. Likewise, the cost of administering the program, including program costs as well as the administrative overhead of insurance carriers and fiscal intermediaries, should be minimized so that a high proportion of program outlays are devoted to delivery of health care services. Finally, the system should promote efficiency, with insurance agencies sharing information and providing coordinated coverage and benefits.

8. Professional liability costs should be minimized.

The direct costs of medical malpractice insurance as well as any indirect costs of added tests and procedures done to reduce the risk of malpractice litigation add significantly to overall health care costs. These costs have continued to rise due to many factors, including the increasing proclivity of patients to sue, legal fees that are contingency-based, excessive jury awards for pain and suffering, and the tendency of insurance companies to agree to out-of-court settlements. Restructuring of the professional liability system, including necessary elements of tort reform, should be an integral part of health care reform.

9. Existing sources of revenue should be incorporated into any new financing system.

For a new system to be financially viable, it must, when possible, continue to capture those resources currently financing health care services. Some savings, of course, may ultimately result under a more efficient system and should be shared among contributors. It is critical, however, that resources now available to the system not be lost, although they may assume a different form. For example, resources from employers presently providing coverage and governmental programs, such as Medicare, Medicaid, CHAMPUS, and VA programs, should be incorporated.

ORGANIZATION AND DELIVERY

10. There should be a sufficient infrastructure in terms of both facilities and manpower to deliver health care services efficiently and effectively.

Health care facilities -- hospitals, outpatient clinics, skilled nursing homes, home health agencies, and hospices -- should be available to meet the full continuum of health care needs. Likewise, the supply of physicians, nurses, and other health care professionals should be adequate to meet requirements for professional services. A new health care financing system must be analyzed in terms of its impact on public hospitals to ensure that the necessary infrastructure for delivery of services is sufficient to meet patient needs. Health planning will be needed to ensure that resources are allocated to meet needs best and to avoid unnecessary duplication, waste, and inefficiency. National policies on manpower will need to ensure that sufficient numbers of the right kinds of physicians and other health care professionals are educated and trained to provide patient care services as well as to meet national needs for teaching, research, and administration.

11. There should be mechanisms to assure quality.

Quality assurance and utilization review should be provided through accepted mechanisms: accreditation and certification standards for institutions; peer review and other quality assurance mechanisms for health care providers. Patients must be able to express their satisfaction or dissatisfaction with the quality of services they receive by being free to choose among providers.

12. Innovation and improvement should be fostered.

Sufficient resources must be devoted to research and development to achieve continued advances in medical science. The system must be responsive to scientific advances, improvements in technology, and changes in medical practice. Issues of maintenance of the health care infrastructure have to be addressed. It is critical that capital resources be available on a continuous basis to enable new construction, restoration and maintenance of existing facilities, and purchase of new equipment and other capital improvements.

13. The system should be flexible.

The financing system should be responsive to variations in patient care needs and preferences concerning how services are organized and delivered. It should recognize the pluralistic nature of our society, accommodating differences in population, culture, and location. The system should permit various organizational models for the delivery of health care services, including private practice, group practice arrangements, health maintenance organizations, and preferred provider organizations.

14. Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive health care and pursue health promotion activities.

Health promotion and preventive health care are effective means for improving the nation's health and reducing health care expendi-

tures. The health care system should, therefore, encourage these activities: prenatal care, maternity care, well-child care, immunizations, physical exercise, good nutrition, healthful life styles, and similar activities that contribute to good health. The system should also encourage Americans to cease unhealthful activities such as smoking, alcohol abuse, and drug use.

SATISFACTION

15. Patients should be satisfied.

The health care system should be satisfactory to patients in terms of meeting their health care needs and providing services. Patients should be able to choose their own physicians and the type of setting from which they obtain health care services. Patients who are dissatisfied with the services they receive should not be unduly restricted from changing physicians or providers. The freedom of patients to choose their own physicians is an important safeguard for assuring quality of care.

Patients should also be able to understand easily how to obtain and pay for care. The financing system should not be so complex that patients cannot readily obtain the care they need. Any use of insurance or claims forms should be fairly simple, so that patients can pay for the services they receive and obtain appropriate reimbursement.

16. Physicians and other health care professionals should be satisfied.

The health care system should foster an environment in which physicians can work effectively and be reasonably satisfied. Such an environment would provide appropriate compensation for physician services and would allow physicians to practice without undue outside interference in clinical decision-making or burdensome administrative and paperwork requirements.

Appropriate professional judgment should not be impeded. Making clinical diagnoses and decisions regarding the management and treatment of disease are challenges that are hallmarks of the medical profession. Inappropriate infringements on this activity may discourage the most promising candidates from seeking or remaining in medical careers. Therefore, the financing system should not unduly influence clinical decision-making, except to the extent that payments should not be provided for inappropriate and ineffective services. Physicians and other health care professionals must be able to determine the most appropriate course of treatment, within the necessary limitations of their scope of expertise, the circumstances of specific patient situations, and scientific knowledge and clinical standards. This is one of the major challenges that attracts students to enter careers in medicine. Unreasonable infringement on professional judgment in patient care decision-making limits physicians' ability to care best for their patients and is a major source of frustration for those in practice.

ASSESSMENT OF ALTERNATIVE APPROACHES TO IMPROVING ACCESS

In the position document published on May 1, we analyzed six major types of proposals that use insurance mechanisms for expanding access. Each of the generic categories of proposals could be fulfilled by many variously structured plans for improving access. The six approaches considered were as follows:

- o Encourage individuals and employers to purchase private insurance
- o Mandate employer coverage
- o Create health insurance risk pools
- o Extend Medicaid eligibility
- o Expand charity care
- o Establish a universal access to health insurance program

Detailed commentary is contained in our full position statement, however, of special relevance to the ongoing Congressional debate are propos-

als for mandating employer health insurance, expanding Medicaid, and establishing a universal access to health insurance program. Our initial thinking on these alternatives is summarized below.

Mandate Employer Coverage

Requiring all employers to provide a certain package of health insurance benefits could extend insurance coverage to approximately two thirds of the uninsured population and could improve coverage for many who are underinsured. However, this approach would provide only a partial solution and would need to be coupled with other remedies. It could contribute to increased unemployment, and it would leave unaddressed the inefficiencies and inequities of current insurance mechanisms, including high overhead costs and multiple and conflicting administrative burdens for health care providers and patients. However, because of its ability to expand coverage rapidly for a significant portion of the uninsured population, this mechanism warrants consideration as a partial, short-term solution to the present problem.

Extend Medicaid Eligibility

Expanding Medicaid eligibility might be a desirable, short-term means for improving financial access to health care services for those who are poor or nearly poor but do not qualify for public assistance. Establishing uniform, minimum eligibility standards could reduce some of the present inequities in coverage and benefits among the states. These improvements would require substantially greater amounts of federal and state funding, amounts that would be difficult to achieve at a time of budgetary constraints. Overall, this approach could serve as an interim means for improving access for low-income groups, particularly for those below the poverty level who qualify for Medicaid in some states but not in others. However, because of the social-welfare nature of the program and the low payment rates that restrict access to care, we do not advocate this approach as the primary, long-term means for increasing access to health care for all Americans.

Establish a Universal-Access-to-Health-Insurance Program

Universal health insurance programs utilize an insurance mechanism to protect all eligible participants from the costs of health care services. A universal access program could be provided through either the public or private sectors or by some combination of both. The key feature would be that a uniform insurance mechanism would spread the risks of health care costs equitably on a nationwide basis.

The primary advantages of a universal access program are that everyone is covered and that coverage is continuous, regardless of changes in place of residence or employment. All participants are covered for specific health insurance benefits and have financial access to mainstream health care. Nationally administered programs in other countries have administrative costs that are much less than those now borne in the United States, primarily because there is less administrative overhead involved in the billing, processing and collection of claims. Disadvantages include the potential for greater governmental intervention in the practice of medicine and in clinical decision-making, loss of physicians' ability to set fees, more intense pressure for cost containment, and more overt rationing of health care services.

CONCLUSIONS AND RECOMMENDATIONS

Having reviewed the major, alternative types of proposals for financing access to health care services for all Americans, the College concluded as follows:

> A nationwide program is needed to assure access to health care for all Americans, and we recommend that this be adopted as a policy goal for the nation. The College believes that health insurance coverage for all persons is needed to minimize financial barriers and assure access to appropriate health care services.

Assuring access also involves issues of cost and quality. The medical profession bears responsibility to ensure that acceptable, appropriate, and cost-effective care is delivered.

Although several of the proposals that we reviewed may provide a needed short-term solution to aspects of the access problem, it is our position that a longer-term view is necessary:

A comprehensive and coordinated program to assure access on a nation-wide basis is essential. In the near term, given the urgency of the need, it should build upon the strengths of existing health care financing mechanisms. In the longer-term, careful consideration of new and innovative alternatives, including some form of a nation-wide financing mechanism, will be necessary.

Expansion of Medicaid and mandated employer health insurance require immediate consideration for bringing prompt relief to a large segment of the population presently without adequate access to health care. Although these short-term approaches have serious negative implications for achieving long-term reform, they bring a certain immediate amelioration of intolerable conditions that now exist.

The time has come for a careful examination of the entire structure of the American health care delivery system. Alternative approaches for achieving greater access to health care services must be carefully considered, including the possibility of a unified insurance mechanism. If any single aspect of the criteria for a better system drives us towards this conclusion, it is the staggering administrative burden of the present system, both in the obvious expense of its administration and the rising bureaucracy and paperwork that it engenders.

Therefore, we urge extreme caution in merely building on the present structure. Although this approach has appeal for various political and practical reasons, we will continue to argue that some proposed solutions should be considered short-term remedies and that the time has come for a thoughtful re-examination of all aspects of the present health care system.

Serious consideration of any form of a universal access to health insurance program would be likely to generate considerable controversy and could be divisive for the medical profession. Adoption of such a program would involve a substantial restructuring of the entire U.S. health care system and, therefore, should be approached thoughtfully and with caution. Experience with the Medicare and Medicaid programs has given many, if not all, physicians cause to be leery of further governmental involvement in health care and skeptical that significant administrative savings would be achieved under yet another national program. Nevertheless, we believe that there is much that can be done to improve the accessibility, quality, and efficiency of our health care system. Some type of coordinated, comprehensive program is required on a nationwide basis.

I appreciate the opportunity to appear before you today and would be pleased to respond to any questions the Subcommittee members might have. Thank you.

Chairman STARK. Thank you very much.

Mr. Coyne.

Mr. COYNE. If we were to do nothing in the next 5 years, would there be more uninsured individuals throughout the country in 10 years?

Dr. GREENBERGER. Absolutely, yes. I think that the current system is under stress for a number of reasons. I think—I haven't mentioned this in my statement today, but I think the stresses involve not only the patients, but also the providers.

Physicians are increasingly dissatisfied and disillusioned with the problems they are having with their patients gaining access to the system, and with the administrative burdens that have become quite onerous.

We are seeing this in the fact decreasing numbers of students are opting for primary care practice, in internal medicine and other primary case disciplines, and we feel this has important implications for the future, as it will also, if the trend continues, jeopardize the access to care and jeopardize the care for the uninsured and elderly in the future.

Mr. COYNE. Would you care to comment on HHS Secretary Sullivan's statements that the private sector should handle the health insurance crisis for the most part, and keep some Government involvement?

Dr. GREENBERGER. I think the lessons of the last decade have taught us, while a private sector can offer certain advantages, these problems have now reached the point where we need to seriously think about systemic reform.

One of the strongest cases I think we can make is the system is not serving patients well. It is not serving the uninsured as well as the insured. It is not serving doctors well. It is not serving the Government well. And the costs are out of control.

If you put all of those factors together and recognize they are interrelated, you come to the conclusion we need to consider systemic reform rather than extending the current system.

I think one of the liabilities of the current system, it is an extension of what we did in 1965. We are dealing with a system now that was designed for $15 x rays—$15 office visits and $25 x rays. Not $800 endoscopies, not $2,000 a day in intensive care unit. Until we address these multiple problems, we are not going to be solving some of these pressing problems.

Therefore, I can understand those statements being made, but I think we need to focus on what we need. I indicated the debate should center on what we need to accomplish. After that, we can begin to think about financing mechanisms.

Mr. COYNE. Former President Reagan used to be quoted as saying, Government is the problem and not the solution. It seems like in this instance, Government has an opportunity to be part of the solution, and I can't understand the rejection of any involvement of Government participation in a national health insurance.

Dr. GREENBERGER. We agree. I think all parties should be sitting down to try to gain consensus. It is not a question of whether the Government is going to be involved, it is a question of how the Government is going to be involved. We certainly agree with that.

Mr. COYNE. Thank you.

Chairman STARK. Doctor, thank you.

Let me, for the first time in the history of the U.S. Government's involvement in providing medical care, see if you and I can establish a unique moment in history, having a certified physician and a certified liberal Member of Congress come to a few points of agreement on what we ought to do.

I am going to set aside the issue of providing the highest quality care for a moment and suggest we turn to adequacy. Adequate medical care I would define as saying that you could get a transplant done by a heart surgeon who made $300,000 or $400,000 a year, instead of going to one who makes $600,000.

And there are other surgeons—at least a half dozen in the country—who can perform this service quite adequately. We don't all have to have a superstar.

First of all, I am going to presume that in your career, you have worked closely with hospital administration officials?

Dr. GREENBERGER. Yes, I have.

Chairman STARK. OK. You have been in private practice, as well as in academic practice.

Dr. GREENBERGER. I have a practice at an academic health center. I look after perhaps 700 patients, all total.

Chairman STARK. And are you generally, if not intimately, familiar with Medicare and how it affects hospitals and physicians and their practice, and the beneficiaries of the system? Is that fair?

Dr. GREENBERGER. Yes, I am.

Chairman STARK. I guess what I am going to try and go through here are your points, and first of all, to suggest that there is probably nothing wrong with the present American medical care delivery system, if all people had access to it and could afford it.

Is that a fair statement?

Dr. GREENBERGER. That is one of the greatest strengths of our system. We have excellent care that is delivered to patients, and we have outcomes now—we have diagnostic technology and treatments that are beyond the dreams of physicians 30 years ago.

We can provide wonderful care to patients when they can access the system.

Chairman STARK. So, if you were going to plan a system, we could probably stipulate that we ought to leave the delivery system alone for now. The delivery system is fine, it is just a few people that can't get into it. Is that a fair assessment of where we are?

Dr. GREENBERGER. I want to hark back to a point I made earlier. The delivery system is working fine. The entry system is obviously an issue. I have highlighted the need for systemic reform. We have a number of very significant administrative burdens that are affecting practicing physicians everywhere, and they are becoming dissatisfied and disillusioned, and they are the very strength of our system.

I think not only is there an access issue, but that access issue is impeding on their very function. For example, in my practice, I have had patients I have looked after for 15 years, and their employers have changed their insurance coverage. These people are without insurance. They delay in seeking my services, even though I assure them I will take care of them.

The access issue impinges on physicians' practices in a very real way.

Chairman STARK. I guess I am coming back to the Medicare system. We have had the Medicare system since 1965, and I am going to suggest and ask if you would agree, that on balance, the beneficiaries are pretty happy with what is provided with Medicare.

Dr. GREENBERGER. I think they are happy in some respects. I think they are concerned with some of the administrative burdens. I can cite some examples.

Chairman STARK. I am talking about the beneficiaries.

Dr. GREENBERGER. I would still like to cite this example, because I think it points out some aspects of the Medicare system that are problems.

I couldn't agree to the assertion that the Medicare system is the ideal system.

Chairman STARK. No, no, but name a better one. Blue Cross in Kansas? Is it better?

Dr. GREENBERGER. I think that——

Chairman STARK. Aetna, Cigna—name a better one in Kansas—I am not suggesting they all can't be reformed, but I am trying to establish here that Medicare is a system that works OK.

Dr. GREENBERGER. Medicare is a system that works OK and has significant problems that we can come back and talk about, if you so desire.

Chairman STARK. I am really not trying to make a case that Medicare doesn't need a lot of improvement. We already know what the scope of the benefits are under Medicare and arguably, we know they have to be improved. We could provide first dollar coverage, one would suggest, for children and certainly for pregnant women, and if we had the money for every American in terms of whatever preventive care is needed. We know though what the benefits are under Medicare.

All right. There are uniform minimum benefits, right? OK. The coverage decisions should be based on clinical effectiveness. Not yet though. Maybe with the outcomes research, we will get there, but arguably, there is no insurance program, commercial or public, that really decides what benefits would be provided under clinical effectiveness.

Dr. GREENBERGER. I think there are some broader questions here. We live in an era of high technology, and one of the things we have to do is educate both physicians and patients that at the ends of life, where things get very costly, just because it is available, we shouldn't necessarily use it, especially when it is not going to be effective.

Each week, at our hospital, we see patients 80 and 90 years of age who are in intensive care units that are costing $2,000 a day, and I would assert that is not effective use of our resources.

Chairman STARK. Doctor, I would, too, but you have just presented politics with an issue from which they will depart with all haste. I would stipulate that it should go on in every district except the Ninth District of the State of California, and my colleagues would hasten to join with me.

You have touched on a very, very sensitive point, and I am going to set that one aside, if I can.

You say the coverage and benefits should be continuous and independent of place of residence and employment. Medicare fills the bill. Financing should be adequate to eliminate financial barriers to obtaining needed care. If that were provided for people below twice poverty, as Medicaid does now, that probably would cover the spectrum.

Dr. GREENBERGER. There would still be people who would not want to be in a position to pay anything out-of-pocket. We have a problem now. We would estimate there may be 1 million Americans out there that don't have health insurance, and they delay seeing doctors, and we don't know anything about them because they are not listed on the rosters of showing up without insurance.

They delay because they anguish over their inability to pay anything.

Chairman STARK. And they won't go and apply for Medicaid?

Dr. GREENBERGER. That is correct.

Chairman STARK. Mechanisms are for controlling costs. Arguably, they are in Medicare. Arguably, they are contentious, but they are there. Medicare has a whole system for controlling costs, whether or not you or I or the hospitals like it, it is there. Do you agree with that?

Dr. GREENBERGER. They are there, but one can question the degree of their effectiveness.

Chairman STARK. There is no question about that.

Dr. GREENBERGER. Considering the absolute cost involved, and the college has tried to make the point that the administrative costs of our current health care system are staggering. If you look at the costs from physicians, hospitals, nursing homes, and insurance carriers, the estimate is $120 billion, an amount that exceeds all the professional fees.

Chairman STARK. Doctor, do you know where that $120 billion comes from? A single payer. I don't care if it is Blue Cross or Medicare. If there is one payer, your hospital in Kansas, we are told, could get rid of one employee per bed—how many beds are in your hospital?

Dr. GREENBERGER. 500.

Chairman STARK. You have 200 clerical people sorting out insurance billing. I bet you have at least that many. Am I close?

Dr. GREENBERGER. I don't have the precise numbers.

Chairman STARK. The point is, if there is a single payer, I am talking about the DRG-type payments for everybody that comes into your hospital, you will do away with a couple of hundred clerical jobs.

You multiply that by 1 million hospital beds, and I will come back to why your hospital won't go broke under this system in a minute.

I know you are going to have different approaches at each step of the way, but I want to come back to suggest to you that this system is at least complete, and I want to get you to focus on how we will pay for this. Because if you don't want Medicare as an insurance system, as a single payer, then I think it is incumbent on us to develop a system we can all deal with.

Why should you and I invent new systems? We can improve on the ones we have. I have no quarrel with Blue Cross-Blue Shield. I have no quarrel with Cigna. I have no quarrel with Aetna. I have no quarrel with Medicare.

Really, I think you get as few complaints about Medicare as you do about Blue Cross. Why not take one of them and improve it, and not worry a lot of the people. Why put everybody into an HMO? A lot of your colleagues don't want to practice in an HMO. As long as they are under Medicare, patients could still choose an HMO, they could still choose a hospital, and your colleagues could still choose to go to work in private practice, or into a group practice.

We pay them. Arguably, there are different amounts. I guess what I am coming to is that we should just stipulate that every American would have coverage, and it would be provided by a social program as opposed to an employee-based program. We could let the employers pay something, but why should we have to identify everybody's attachment, to an employer to get them into a system?

Who deals with kids if there is a divorce? If there are two employers, which employer pays for two kids? We wrestled with that in the Pepper Commission to the point that we were going to do it by body weight.

The simpler solution, it seems to me, is that we all ought to pay. The social costs of 100 percent access on the acute care side are zero. Basically, people who don't get covered now end up in an emergency room or need higher cost care, as higher risk patients, and we all pay more to cover them.

I just want to end by complimenting you and your group for getting almost to the end of the problem. Now, I am going to tell you it is going to cost $60 billion to provide coverage for acute care.

The Pepper Commission came up with fortification, but they left out the $20 billion employers would have to pay. What I am telling you is the Pepper Commission, and myself and Mr. Coyne, one of the original cosponsors, came up with about $60 billion developing a social based system and picking up everybody. You could pay for that in a lot of ways, and that is going to be the tough part for the public to swallow.

The other $60 billion of what I am proposing is long-term care, and that is something that is new. So, I hope all of you will keep pushing at this, because I gather you are not foreclosing any approach to solving it, but also, keep reminding us, as you did, Mr. Coyne, that there is a problem, and it does cost us more.

I would like to counter Secretary Sullivan. He says Canada has a lot of waiting. A lot of rationing. If we must ration, would you rather ration by income?

Dr. GREENBERGER. We would rather have rationing, because the poor can't access——

Chairman STARK. Canada rations, as I understand it, clinically. The doctor decides, a person's income doesn't. I think it is the opposite in this country.

Dr. GREENBERGER. I think this is one of the education jobs we have to do with the public, whose expectations are a little unrealistic in terms of what can be accomplished in the future.

We have to stress with our rapidly proliferating costs, the continued high technology, and the appropriate allocation of resources, there inevitably has to be some rationing.

Chairman STARK. Actually, I will spot you the costs. I am not sure I feel indignant spending 12 percent of our gross national product, although Canada is only spending 8, if everybody could participate.

So, we spend $600 billion, but then let's enjoy it, everybody. You know, not just Donald Trump, but let's all have long-term care. Let's spend $700 billion, but then let's get everybody into the system.

I would rather start that way than say, let's cut $100 billion out of this system, when we haven't even got this $30 million in. I am not so sure we won't always be a high-cost country.

Innovation costs money, research and pharmaceuticals cost money. Maybe that is part of it, but for what we have got let's get everybody else in there. I will let some of my colleagues ask questions.

Mr. Moody.

Mr. MOODY. I was just enjoying the dialog between my chairman and our witness. And I want to say that I agree with the comments of the chairman and I also appreciate your views Dr. Greenberger and thank you for being here.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

I want to compliment the witness on a very comprehensive statement before our committee.

I would like to follow up on one statement. You indicate there should be incentives for patients to obtain and for health providers to deliver health care services in a cost-effective manner.

We have had managed care. We have had caps. We have had peer review, all in an effort to carry out that objective. Do you have any other specific suggestions that we should look at in order to offer those incentives to patients and health care providers to provide a more cost-effective system?

Dr. GREENBERGER. That is a very complex question. It requires a detailed answer. I think it begins with enhancement education, education as to the realities and practice of medicine these days, and costs.

It relates to the development of practice parameters and guidelines, which will further allow physicians to provide rational care for their patients. It should deal with reducing malpractice costs.

I think all of these are interrelated, and I think they can be dealt with. I think the costs are out of control. One of the places to look are at the administrative costs, which are inordinately high.

Mr. CARDIN. Educating the consumer; talk a little bit more about that. How do you think a consumer of health goods could make more cost-effective decisions?

Dr. GREENBERGER. I think the practitioners of medicine have an obligation to present to their patient at all times specific recommendations for healthier lifestyles. We are talking about stopping smoking cigarettes, keep your cholesterol down.

A lot of physicians' organizations, including ours, have health newsletters we are putting in doctors' offices with the hope and ex-

pectation they are going to give those to their patients and talk with them about those things.

I would assert an insufficient number of physicians actually take the time to talk to their patients about these very, very important issues and explain the system to them.

Mr. CARDIN. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody.

Mr. MOODY. I would like to follow up a little bit on the issue of cost effectiveness. You provide a useful framework for us to discuss this issue using that framework as long as the net benefit of a procedure exceeds the net cost, how will we ever get people to make cost-effective tradeoffs? How do we get people to take cost into account when a procedure is beneficial, even if that procedure is not the most cost-effective?

As long as a procedure holds out any hope of relief, people are going to be asking for it. How does a doctor say, no, no, no, that procedure has a 20-percent chance of being effective and 80 percent of the time the money, the cost and resources are being wasted. How do you tell that to a patient?

Dr. GREENBERGER. I think, again, with proper education you have an opportunity to do that. I think increasingly, physicians are obligated these days before they make recommendations to have a clear understanding of the utility of a diagnostic test. What is its sensitivity, what is its specificity, what is the likelihood of it providing the information that is needed.

As this process becomes more fully developed and patients participate in that, I think the physician is going to have to take the lead role when patients come in our offices every day and say, and ask why can't I have a C.T. scan or MRI, because they are knowledgeable.

They watch Lifetime Medical Television. They will contest to some extent physicians' recommendations. Physicians have to be armed with the appropriate information, and believe in the utility of procedures and make these important decisions.

I think if there are parameters spelled out for the appropriate use of this high technology, I think we can make inroads in this very important problem.

Mr. MOODY. Let's take prostate problems. There may be prescription drug treatments or there may be surgical treatments as options, one or the other. I guess what I hear you say is that doctors could tell the patient, "If we do surgery, these are the pluses and minuses. If we try medication these are the pluses and minuses. Are you saying the decision should be in the hands of patient?

Dr. GREENBERGER. I think the physician has to be in a position to make an appropriate recommendation. The patient has to be informed of the options and the expected benefits, and the expected liabilities.

Chairman STARK. Will the gentleman yield?

Mr. MOODY. Yes.

Chairman STARK. Are there any circumstances in the scenario just suggested by my colleague from Wisconsin in which the decision ought to be made on the basis of cost?

Dr. GREENBERGER. No. I think we are talking about utility, and I think one of the key issues here is to look at some of these procedures that are overpriced.

Chairman STARK. I agree with you.

Dr. GREENBERGER. That does not become the issue.

Mr. MOODY. You have two things going on simultaneously. In choosing between treatment regimes, you have nonmonetary costs, that is, there may be some negative side effects associated with treatment regime, and there are probabilities associated with those side effects.

You never know 100 percent for certain, but you have experience. So you have the nonmonetary consideration. Then of course, you have the monetary costs. Do you try to weigh the cost of benefits of treatment A versus treatment B? Are you suggesting that after the recommendation, the patient should make the ultimate choice?

Dr. GREENBERGER. I didn't say that. I said the patient should participate in the decisionmaking. Many patients these days want to know the pros and cons of doing A, B, C, or D, and I think the physician is obligated to go through that information with them.

The physician ultimately will make the recommendation to them. Most of the recommendations will be accepted by the patient involved.

Mr. MOODY. In some cases, you might have a choice between more aggressive treatment regime or a less aggressive one. Those are decisions the patient should be brought in on. You say it should be a consensus process with the patient and doctor, a joint decision?

Dr. GREENBERGER. Yes, sir.

Mr. MOODY. On the other side of the ledger, when you don't have nonmonetary costs to consider, and procedure A costs 10 times more than procedure B, but is only twice as likely to be of more benefit, then do we let that be a consideration? Isn't that inevitably a relative calculation?

Dr. GREENBERGER. I think the vast and overwhelming majority of physicians would go with the best procedure for the patient.

Mr. MOODY. Irrespective of cost?

Dr. GREENBERGER. Yes.

Mr. MOODY. Doesn't universal coverage almost always inevitably result in some sort of cost considerations?

Dr. GREENBERGER. You look at colon cancer, and you look at a barium enema, which costs $250, or colonoscopies, $500. The colonoscopy is the better procedure, period. Therefore, it should be the primary means that is employed. In other countries, there might be a differential, but they would make the decision the same way.

Mr. MOODY. Let's suppose the colonoscopy costs 20 times as much, but is only twice as likely to be effective, so the cost-benefit ratio was not as good in a statistical sense. For a given individual, like hitting bingo, it might be the perfect answer.

Does the doctor or society have the right to tilt the choice-making playing field here towards the more cost-effective?

Dr. GREENBERGER. Yes. I think that is one of the reasons we need more of the research into the effectiveness of various treatments

and diagnostic tests, what have you, so these questions can be answered much more clearly.

Mr. MOODY. You think cost is relevant at some point?

Dr. GREENBERGER. I believe cost is relevant at some point, a part of the equation.

Mr. MOODY. OK. That is very important. Some say that it's the camel's nose under the tent to say yes to that question. There are some people who feel cost should never be relevant. In a universal system, you inevitably come around meeting yourself where it has to be relevant. Everyone doesn't always get the Rolls-Royce model. Right.

How we confront the problem of telling Mrs. Jones she can't have the Rolls-Royce is the tough issue. I guess some universal systems in England or elsewhere handle it differently than others, but we have to face that.

Dr. GREENBERGER. We are facing that already.

Mr. MOODY. Implicitly facing it, but not explicitly facing it. Thank you.

Chairman STARK. Doctor, before we let you go, I just wanted to follow up a little bit.

When you talk about the beneficiaries of these plans having various incentives, do you leave out of that the idea that they ought to be forced to shop for a test or a surgeon or an anesthesiologist?

I always take up the position that the patient really doesn't have the expertise at the time those decisions have to be made, and isn't in the frame of mind to say to the primary physician, can you get three bids before I take the blood test? I don't think you mean to suggest that people would use less medical services if we just raised their 20 percent to 23 percent or something of that nature.

I am not suggesting that is a great area for savings. Would you concur?

Dr. GREENBERGER. I concur.

Chairman STARK. At the moment you are making the decision, when somebody has mentioned the word "cancer," or heart attack, everything you learned when you got that economics Ph.D. goes out the window. You just say, "Oh, my God, I hope it doesn't hurt."

In the aggregate, I would concur, but individually, I would say we are as scared of that as the next guy.

Mr. MOODY. We are talking many different things: life-threatening diseases, a sprained ankle and other things. By the way, Mr. Chairman, when you referred to behavior issues, when you referred to substance abuse, I assume you were not referring to beer.

Chairman STARK. Right.

Dr. Greenberger, thank you very much. We look forward to having the American College of Physicians, who have done a wonderful job, working with us on the benefit question and the delivery question and coming back next year or later this year with their outline of how we are going to pay for this. That is the second chapter.

We look forward to it with bated breath.

Mr. Pickle, I am sorry. Dr. Greenberger, would you hold on a minute?

Mr. PICKLE. All I would say, Dr. Greenberger, while I wasn't here to hear your testimony, I have read it and looked it over, and I

commend you for your positive attitude. You and your organization recognize that we have got to have access to health care. Somehow, millions of people are not being covered.

We need to get them under the umbrella some way, and at least your organization is trying to develop a plan. While the committee may not agree with your approach or even the chairman's approach, at least you have given an indication as a professional group and as individuals, you think something ought to be done about it.

I commend you for your testimony.

Chairman STARK. Thank you, Doctor.

Now we are going to have a panel of three witnesses representing three groups who also think that something must be done, and we are going to hear from our former associate, Paul Rettig, who is the executive vice president of the American Hospital Association; Edward J. Foley, chairman of the board, National Association of Public Hospitals; and Sister Mary Roch Rocklage, R.S.M., former chairperson, Catholic Health Association, and presently chairperson, Select Committee on Indigent Care.

It is my understanding each of the witnesses' organizations are concerned with the access, coverage and cost of health care. Some may have a complete program to suggest and some may tell us how far down the road they are toward achieving a program which they would like to submit to us.

I am pleased to have all three of the witnesses here. We will start with Paul, if you would like to lead off.

STATEMENT OF PAUL C. RETTIG, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. RETTIG. Thank you, Mr. Chairman.

I am pleased to be here on behalf of the American Hospital Association to discuss ways to address the growing need for reform of the health insurance system. I would like to commend the subcommittee and the chairman for exploring this subject.

We know you are as eager as we are to work for reform of health care and financing arrangements, and we look forward to working with you.

As has been already said, the need for reform is clear, illustrated first and foremost by the 37 million uninsured. Hospitals are well-acquainted with this problem. We see these problems, in emergency rooms for example, where mothers come to deliver babies, but not to receive prenatal care, or people come to emergency rooms with serious illnesses that could have been treated less expensively earlier.

So we clearly are in favor of reform and do have a existing position that I will talk about briefly.

We also have under way a more elaborate examination of system reform that will probably not be completed until the end of this year.

The problem, as we see it, is associated with the erosion of the traditional link between employment and insurance. That system is breaking down and weakening in various ways. The Medicaid program is deteriorating in terms of its coverage.

A growing number of people living in poverty are uninsured, and there is inadequate private insurance or Government-sponsored coverage of long-term care. So, under our current position, we support combining Federal mandates and tax incentives and other subsidies to make employer-provided insurance available to all workers and their families, and reforming Medicaid eligibility policies, enrollment incentives, and financial reimbursement, to help the Federal Government meet its obligations to those who cannot afford insurance.

And, third, we encourage public- and private-sector sharing of the responsibility to assist Americans in providing for their long-term care and needs.

Let me speak briefly about the current position of the association as it relates to the mandated benefits. We have criteria that we think should be met by in any such plan. We believe all employers should be included, although there may be a need to phase in the requirements. We think all employees should be covered, and their dependents.

We believe coverage should be provided for reasonable and necessary acute care, prenatal and well-baby care, preventive care services that prove cost-effective, and out-of-pocket expenditures with reasonable limits should be allowed.

We believe employers should make a significant contribution toward the premium cost. We believe the public and private sectors should work together to make risk pooling arrangements available so private insurance would work better.

As already stated, we believe there may be a need to phase in the requirements and to provide special tax incentives or special hardship funds for employers with certain characteristics.

Finally, we believe employees of noncomplying employers should be enrolled in an appropriate State-offered plan, and the employer assessed a fee to cover the premium plus a penalty.

In other words, our current position supports a pay or play kind of approach. In terms of Medicaid reforms, as stated, we believe there are too many poor people not covered by Medicaid and too often, needed services are not included.

Much too often, Government payment for covered services for those who are eligible falls below cost. So, there is need for Medicaid reform. In the long term, our recommendation is that a federally financed Medicaid program be expanded and revised, and be organized into separately administered programs with three distinct parts.

One part for those who are not eligible for Medicare—acute care coverage for these people. A second part, for people who are Medicare beneficiaries and have financial needs—supplementary acute care coverage. Third, long-term care coverage for low-income individuals.

Medicaid should be decoupled from cash assistance programs, and there should be uniform eligibility and coverage standards. That is sort of in the intermediate long-term range.

As for immediate incremental improvements, we have a series of recommendations, some of which I will just list, which include: minimum payment adjustment for Medicaid disproportionate share payments; prohibiting application of an upper limits test on pay-

ment; prohibiting fixed durational limits for medically necessary hospital services; extending the current disproportionate share adjustments to outpatient services. A phasein of a national minimum eligibility floor; and a phasein of coverage of pregnant women, infants and children up to 85 percent of poverty.

We also encourage a congressionally mandated study on inadequacy and inequity of Medicaid hospital payments.

In the area of long-term care, we recommend a system of combined private and public funding that encourages individuals to provide for their own long-term care as much as possible, ensuring access to needed long-term care when individual resources are inadequate.

We have specific, more detailed recommendations in our statement.

As to the matter of financing, which the chairman has pointed out is important for people to speak to, our view is that the private sector initiatives should be funded through premiums paid by both employees and employers, and the public sector initiative should be funded through a combination of broadly based taxes and premiums. The principal source of funding for public sector programs would be higher taxes.

That summarizes where we are so far, before we undergo a further assessment of the future of health care. We are attempting a kind of bottom-up decisionmaking exercise within the hospital community; which means that our regional policy boards are each looking at a whole series of issues, and, in an incremental way, we are working our way through a series of principles and recommendations.

As the process goes on, we will begin to be more specific and we hope a detailed plan will take shape. We are not able yet to tell you what that will be. I want to speak briefly now about several reform criteria which the exercise so far has developed.

Let me go through them quickly. There are nine of them. We think these are criteria by which any plan ought to be judged, and which we hope any plan would in fact meet.

First, essential services should be available to all, that is the access issue, and we believe it is important essentially that there be universal access—to be to at least basic health care services.

Defining "basic"—what is the minimum we think everybody should have available—is a difficult problem which we are working on. We will probably argue with each other a good bit before we have any specific recommendation on that.

Of course, we believe that the system should be one organized in terms of its delivery arrangements and its financial arrangements—that promotes high quality of care. That has various aspects, including the payment and provision of effective care only, and a notion of cost-effectiveness.

We believe the system should be adequately and fairly financed. That means both the payments should be adequate and the financial burden should be distributed in a fair way across society.

We believe the system should be affordable, meaning people should be able to choose what level of expenditures and how rich a benefit package they want to have and are willing to pay for.

We also believe that in public programs—should there be a need to limit the scope and size and cost of what they are paying for—it should be explicit in terms of restricting benefits or restricting choice of provider, rather than just spreading the restriction of financial resources in a diffuse kind of way so nobody is responsible.

We want to encourage efficient delivery of services. We believe the system should be one that is community-focused and patient-centered, managed at the local level, responsive to individual patient and consumer needs, and that fosters appropriate expectations for care. That is a notion that was mentioned earlier today.

We believe in terms of supply that it should be sufficient for timely access. That means the system should be one that encourages preventive services where these are valuable, rather than waiting until a condition develops and trying to treat it; And similarly, that recognizes that there is a time in which services ought to be provided and if there is a delay, this may be inappropriate. So we think timely access is important.

We have a criterion we call user-friendly, kind of a catch-all to respond to the kinds of concerns that people have with the insurance and payment system today, in which people get confused about what is covered, and how to apply for it. Providers are confused about the requirements that will be imposed on them, and an objective is to make this user-friendly for all parties.

And, finally, we believe the system should in some way be conducive to innovation, not limiting new developments and effective methods of treatment. That is where we are at the moment.

We do believe significant reform is called for. We have a current position which we are not ashamed of at all. We are trying to think more deeply on what further changes may be necessary.

We look forward to working with the committee. Thank you.

[The statement of Mr. Rettig follows:]

American Hospital Association

Capitol Place, Building #3
50 F Street, N W
Suite 1100
Washington, D.C 20001
Telephone 202 638-1100
FAX NO 202 626-2345

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives

July 24, 1990

SUMMARY

The growing number of uninsured and underinsured Americans presents a major challenge to private- and public-sector health policymakers. The problem has its origins in:

The erosion of the traditional link between employment and insurance;

The recent deterioration of the Medicaid program; and

The inadequacy of private insurance for or government-sponsored coverage of long-term care.

This crisis calls for immediate, strong action from both the public and private sectors. For the short term, the American Hospital Association (AHA) recommends:

Combining federal mandates and tax incentives and other subsidies to make employer-provided insurance available to all workers;

Reforming Medicaid eligibility policy, enrollment incentives, financing and reimbursement, and service coverage to help the federal government meet its obligations to those who cannot afford insurance;

Encouraging a public- and private-sector sharing of responsibility to assist Americans in providing for their long-term care needs; and

Funding these initiatives through employer- and employee-paid premiums and broadly based taxes.

For the long term, the AHA is developing a National Health Care Strategy to identify the problems with and make suggestions for the reform of the health care delivery system. We have identified key criteria against which any reform proposal can and should be measured.

INTRODUCTION

Mr. Chairman, I am Paul C. Rettig, executive vice president of the American Hospital Association. I am pleased to have the opportunity to be here today on behalf of the AHA's nearly 5,500 member institutions and more than 48,000 personal members to discuss ways to address the growing need for reform of the health insurance system.

33-773 0 - 90 -- 3

The need for health insurance reform is clear. Nationally, 37 million Americans are medically uninsured, millions more are underinsured, and the number of medically indigent grows every year, in good economic times as well as bad. Hospitals strain to meet the needs of the medically indigent, with the current bill for indigent care services topping $8 billion annually. Although the uninsured eventually receive care, they tend to seek too little care, too late. They come to hospitals to deliver their babies, but not to receive prenatal care; and they come to emergency rooms with serious illnesses that could have been treated less expensively a year sooner. They come to us after they have depleted their few economic resources to pay for care, thereby assuring that they will have no resources to recover from the financial devastation of illness.

Much of the rise in the number of uninsured has been caused by the recent deterioration of Medicaid coverage. Medicaid covers less than 40 percent of the poor population; a decade ago it covered 65 percent. But much of the problem of medical indigence also stems from the erosion of the traditional link between work and insurance; employers have been covering a shrinking proportion of workers and their families.

For this reason, AHA's Special Committee on Care for the Indigent concluded that an enduring solution to the problem of medical indigence will require initiatives by both the public and private sectors to:

> Reduce the size of the medically indigent population through private health insurance; and
>
> Finance care for the medically indigent who are unable to obtain private insurance through restructured and extended public programs.

Another dimension of the health care access problem is long-term care as it relates to the elderly, the disabled, and the chronically ill. With the repeal of the Medicare Catastrophic Coverage Act, the problem of financing long-term care only looms larger. The responsibility for its solution must be shared by all: individuals, the private sector, and state and federal governments.

HEALTH INSURANCE COVERAGE OF THE EMPLOYED

The U.S. health insurance system is currently built on employer-provided insurance. About 85 percent of the 191 million privately insured Americans now receive insurance through the workplace; federal and state tax policies clearly support this pattern. In 1982, federal and state governments provided a $31 billion subsidy of the privately insured through exclusion of employer-paid health insurance from the taxable income of employees. Nevertheless, nearly 88 percent of the uninsured were either themselves workers or lived in families of workers.

Ideally, AHA would prefer to rely on strong economic incentives and joint private-/public-sector action to induce employers to offer insurance to their employees. But these are no longer enough. The growing "crack" in the private and public insurance system has now become an abyss. This crisis calls for immediate, strong action from public programs and the private sector.

There is considerable logic in extending coverage to many of these people by building on the existing system. The key policy question is how. Two approaches have been suggested: the use of mandates and the use of tax supports, public subsidies, and other incentives. Both approaches are necessary.

For a mandated approach to work, employers must have the tools to comply. A workable mandated approach will require carefully defined mandates to minimize economic dislocations. Essential elements of a workable mandate are:

> All employers should be included, although the time frames and mechanisms for implementation may vary depending on the business's size and stage of development and the problems experienced by small employers or those that are financially distressed.
>
> All employees (except temporary employees) and their dependents should be covered.

Mandated insurance should cover all expenses (other than required cost sharing) for "reasonable and medically necessary" acute care, including acute psychiatric and rehabilitative care, prenatal and well baby care, and any other preventive care services that are proved cost-effective. The mandate should allow out-of-pocket expenditures up to a specified, indexed dollar amount per year.

Employers should make a significant contribution (at least 50 percent) to the premium, with the contribution prorated for part-time permanent employees based on the number of hours worked.

The public sector should work with the private sector to assure that affordable insurance is available through risk-pooling arrangements. To provide time for the development of these mechanisms, the mandate should be phased in over a period of no more than five years and should be combined with special tax incentives and/or the use of special hardship funds to ease the burden for employers who, because of their size or financial status, might find compliance particularly difficult.

Employees of non-complying employers would be enrolled in an appropriate state-offered plan, and the employer would be assessed a fee to cover the premiums plus a penalty.

States should retain authority to regulate insurance, and may require insurers to offer additional benefits, but would not be permitted to require employers or employees to buy them.

AHA supports the concept of federally mandated health insurance coupled with incentives to ease the burden of compliance, as embraced by The Basic Health Benefits for All Americans Act (S.768/H.R.1845). Insurance should be a requirement for doing business, in much the same way that paying a "minimum wage" is a condition of doing business in the United States. Although some have opposed mandates on the grounds that they would impose a substantial burden on business, it must be recognized that all Americans pay the cost of inadequate insurance protection. And big businesses, among which private insurance is nearly universal, pay three times: once for their own employees, once for working spouses of those employees, and once for those who are not insured, in the form of higher prices for medical care.

AHA urges Congress to strengthen tax incentives to encourage both individuals and small employers to obtain health insurance coverage and to make such insurance coverage affordable.

Employer mandates, however, are only part of the answer to medical indigence. If business has an obligation to make insurance available for employees and dependents, government has the obligation to create an environment that will enable business to comply.

MEDICAID REFORMS

Any comprehensive approach to the problem of medical indigence must begin with Medicaid reform--reform not only of state eligibility standards but of payment, reimbursement, and coverage as well. The past several Congresses have made important gains. Medicaid eligibility has been extended to a greater number of pregnant women and children, but much remains to be done.

Despite these recent improvements, the Medicaid program covers fewer poor individuals than ever before--approximately 40 percent of those below the federal poverty level--down from 65 percent a decade ago. The inadequacy of Medicaid coverage is the primary reason for the gap in insurance for children, particularly poor children, and is contributing to the growing problem of access to care for individuals with AIDS.

Too many poor are not covered by the Medicaid program and, too often, needed services are not included. Much too often, government payment for covered services for those who are eligible falls far below cost. In 1988, for example, estimates from available data show that Medicaid paid hospitals nearly $3 billion less than it cost to care for Medicaid recipients. These reimbursement shortfalls are particularly pronounced in the case of outpatient care and with regard to resource-intensive services such as trauma and

neonatal intensive care, as well as care for persons with AIDS. This shortfall makes it difficult for hospitals to discharge other responsibilities. When hospitals are underpaid, they begin a painful and perilous descent that can end with elimination of needed services, and even closure.

With reimbursement in many states falling short of actual costs, many hospitals have mounted court challenges to these reimbursement policies. And a growing number of recent federal court rulings against state Medicaid payment policies have recognized the problem of inadequate Medicaid reimbursement. The U.S. Supreme Court's recent decision on Wilder v. Virginia Hospital Association reaffirms hospitals' right to challenge state Medicaid payment systems in federal court. The need for many hospitals to seek redress in court for inadequate Medicaid reimbursement underscores the need for Congress to act to ensure that all Medicaid payments are sufficient to guarantee every recipient reasonable access to any necessary hospital treatment in a timely fashion.

In the long term, AHA recommends a federally financed Medicaid program expanded and revised into a separately administered program with three distinct parts:

> Acute care coverage for the medically indigent not eligible for Medicare;
> Supplementary acute care coverage for Medicare beneficiaries; and
> Long-term care coverage for low-income individuals.

Further, Medicaid should be decoupled from cash assistance programs with uniform eligibility and coverage standards.

But the problems of eligibility, coverage, and reimbursement are so pressing they require immediate incremental improvements. AHA recommends a series of improvements, some of which include: requiring a minimum payment adjustment for Medicaid disproportionate-share payments; prohibiting application of an upper limits test; prohibiting application of fixed durational limits to medically necessary inpatient hospital services; extending the current disproportionate-share adjustments to outpatient services; a phase-in of a national minimum eligibility floor; and a phase-in of coverage of pregnant infants and children up to 185 percent of poverty. In addition, AHA recommends a congressionally mandated study on adequacy and equity of Medicaid hospital payments.

It is clear that the government will have to continue playing a major role in ensuring that health care services are available to all Americans. As such, public programs to finance care for the medically indigent who are unable to obtain private insurance should be restructured and extended. It is imperative that the federal government fulfill its obligations under existing programs, particularly Medicaid.

LONG-TERM CARE

The responsibility for financing long-term care should also be shared by all segments of society. We must encourage individuals to provide for their long-term care needs to the extent permitted by their income as a way to shield themselves from catastrophic expenses of chronic illness. In addition, we must ensure access to long-term care when individual resources are inadequate and establish a more humane alternative to "spend down" requirements as a precondition for eligibility under public programs. No one should have to dissipate limited assets to qualify for government assistance.

AHA recommends a system of combined private and public funding that encourages individuals to provide for their own long-term care as much as possible and that ensures access to needed long-term care when individual resources are inadequate. Specific recommendations include:

> A separate program of Medicaid long-term care coverage for those needing assistance. AHA does not, however, support a government-funded program to provide long-term care for everyone.
>
> The development of alternatives to the current Medicaid "spend down" requirements to prevent further impoverishment of the dependents of

those with chronic illness. AHA supports a system of federal and state loans as an alternative to "spend-down" requirements for Medicaid eligibility.

The development of private-sector alternatives for financing long-term care, encouraged through tax incentives and demonstration projects. AHA supports the use of pre-funding mechanisms such as medical savings accounts and private long-term care insurance.

An increased emphasis on public programs that offer alternative methods of delivering care that, when appropriate, can keep those with chronic illnesses out of institutions.

Closing the gaps in Medicare coverage of extended care services, including home health, skilled nursing, rehabilitation, and hospital-based transitional care services, and expanding eligibility to all beneficiaries below the federal poverty line. AHA recommends elimination of the three-day prior hospitalization rule for access to extended care services in skilled nursing facilities.

Encouragement of the case-mamagement option for long-term care to help minimize more costly inpatient care and improve quality by promoting better coordination of services and greater use of alternatives to institutional care.

FINANCING EXPANDED BENEFITS

AHA's recommendations on care for the medically indigent and long-term care call for a combination of public- and private-sector initiatives. The private-sector initiatives would be funded through premiums paid by both employees and employers. The public-sector initiatives would be funded through a combination of broadly based taxes and premiums. The principal source of funding for public-sector programs would be higher taxes.

The Special Committee that developed the recommendations on ensuring access for the medically indigent, as noted above, called for a basic restructuring of the Medicaid program. The component of the program that would finance care for the medically indigent who are not eligible for Medicare would be financed through a broadly based tax. Such a tax might take the form of a general income tax or a broadly based dedicated tax such as a special payroll tax. In its report, the Committee recommended that any such tax be structured to provide a strong positive incentive for employers to offer--and their employees to obtain--private health insurance coverage. Such an incentive could be readily incorporated in a dedicated payroll tax. For example, a payroll tax of 2 percent, equally divided between employers and employees, could be established as the basic source of funding for an expanded Medicaid program. Employees who obtain private insurance would be forgiven one-half of this tax, leaving each with a liability of only one-half of 1 percent.

Although raising taxes is never popular, neither is the prospect of millions of Americans continuing to live with the uncertainty of how to pay for the costs of serious illness. The advantages of a broadly based financing system such as that described by the AHA Committee are threefold:

It achieves the broadest possible participation in the funding of care for the indigent;
It encourages private insurance by rewarding those who provide for their own needs; and
It imposes a proportionately greater burden on individuals and employers who choose to remain uninsured but who are capable of financing their own insurance.

In addition, while proposals to raise taxes will doubtless be opposed by many, it should be recognized that the cost of caring for the medically indigent is already borne broadly by society as a whole. Substituting a rational, stable financing mechanism for continued reliance on cost shifting will benefit both the indigent and those who must currently pay for that care. It will also facilitate development of systems for efficiently managing delivery of care needed by the medically indigent by enrolling them in well-designed public programs.

Opposition to higher taxes can also be reduced by charging those who benefit directly from coverage through public programs a reasonable premium tied to their ability to pay. Not all of the medically indigent are poor. Individuals who are employed and can afford to contribute toward the cost of their coverage should be required to do so. A premium contribution by a family should be based on the actuarial value of the coverage it receives and its annual income.

In the case of long-term care, similar principles should be applied. Specific recommendations are being developed by an Ad Hoc Committee of the Board of the AHA. However, as with the uninsured, a long-range solution to the issue of financing long-term care will require a combination of public- and private-sector initiatives financed by tax dollars and individual contributions. Specifically, AHA supports federal tax incentives to promote individual financing of long-term care insurance, including incentives to promote savings and prepaid insurance. However, higher taxes will also be needed to finance long-term care for those whose needs exceed their financial resources. The financing of any program of long-term care "insurance" should, however, be kept separate from the financing of acute care benefits by Medicare.

REFORM CRITERIA

In addition to recommendations to expand Medicaid, employer-sponsored insurance, and long-term care insurance, AHA is developing a National Health Care Strategy to address the need for significant reform of the current health care delivery system. While the project is not yet complete, AHA has identified criteria by which proposals for restructuring health care delivery and/or financing should be evaluated.

In developing the criteria, AHA presumes that any reform may involve substantial change in current delivery and financing arrangements, but should build on the strengths of the existing pluralistic health care delivery and finance systems.

The key criteria are:

Essential services available to all. All individuals should have access to at least basic health care services.

High quality. Delivery and financing arrangements should ensure effective management of medical conditions and promote continuous improvement in quality care. Specifically, they should encourage: coordination of care among providers and across levels of care; improvement of outcome through diffusion and appropriate use of innovations in technology and medical practice; delivery of effective care only; use of the most cost-effective treatment to manage a patient's condition; and monitoring of practice and constructive peer review to identify improvements in practice.

Adequately and fairly financed. Any public or private financing arrangement must itself bear the cost of services provided to its enrollees or beneficiaries under the benefits it promises. The cost of public programs should be broadly and equitably distributed in the same manner that the cost of other "public goods" provided through the public sector is distributed. The outcome for the provider should be fair and adequate payment for services delivered.

Affordable. Patients and purchasers should be able to select benefits and delivery arrangements that emphasize "value" by enabling them to obtain the kind of care for which they are willing and able to pay. Based on availability of funds, public programs for those not able to finance their own care should explicitly limit access to care beyond "basic care" by restricting benefits or choice of provider.

Efficiently delivered. Delivery and financing systems should align the incentives of all providers to promote continuous improvement in efficient use of resources to restore or preserve health. They should also create financial incentives encouraging individuals to adopt healthy lifestyles and responsibly use health services.

Community-focused/patient-centered. Delivery and financing arrangements should be managed at the local level and recognize appropriate community variation in medical practice consistent with

national standards for appropriate/effective treatment, health care needs, and resource availability. Such arrangements should be accountable and responsive to patient or consumer needs; foster appropriate expectations for care; and treat all patients with dignity and courtesy.

In sufficient supply for timely access. Delivery and financing arrangements should allow beneficiaries to obtain care when and at a level of care where it is most likely to change the course of a disease or prevent avoidable morbidity or mortality.

User-friendly. Delivery and financing arrangements should enable patients, providers, and purchasers to obtain, deliver, and pay for needed care with minimum uncertainty and confusion. A "user-friendly" system will enable patients to know: how to obtain care, what care will be covered, and how much care will cost (both in total and out-of-pocket). It will also provide for timely settlement of claims and will not impose excessive administrative burdens or costs on providers.

Conducive to innovation. Delivery and financing systems should promote the development and dissemination of new and more effective methods of treating and preventing illness and delivering services.

CONCLUSION

Significant reform of the current health insurance system is clearly necessary. The criteria discussed above are the first results of the AHA's attempt to devise a national health strategy to achieve such reform. We recognize that development of such a proposal--ours or one of the many others currently being discussed--will be a lengthy and complex process. Actually implementing the changes and reforms decided upon will take even more time.

We plan to continue our work for the future; but, in the interim, we believe the current system can be improved by combining federal mandates and incentives to make employer insurance available, by reforming and expanding Medicaid, and by combining private- and public-sector efforts to make long-term care affordable for Americans.

Chairman STARK. Thank you.

I must say, one of your tenets caught my eye, and I want to go over this with you. On page 16, where you talk about affordable care, as I read this, you are suggesting that Medicaid beneficiaries—if I can rephrase the last sentence of that paragraph—should have explicit limitations on access to care beyond some basic package, and they should be restricted in which hospital they can go to.

Is that what you are saying?

Mr. RETTIG. Among the possibilities we show is choice of provider. As you know, Mr. Chairman, some of that is already going on.

Chairman STARK. I understand that. Do you support it? You say in your language, based on the availability of funds. You say public programs for those not able to finance their own care should explicitly limit access to care beyond "basic care" by restricting benefits or choice of provider. That is what you think the system should have?

Mr. RETTIG. It is an attempt to say a Government program should not hold out promises larger than it can fulfill. And it is a—an attempt to say, I think——

Chairman STARK. You see, I would take the stand a hospital or physician should not know whether you are poor or rich when you walk into that facility. It is one of the things that has led to the dumping of emergency rooms by hospitals. If the emergency room didn't have to know—how would you deal with this in an emergency room? I hate to take such a strenuous exception, but I hope that is an area you could rethink.

Would you restrict those individuals under the CHAMPUS system? Would you restrict those in rural areas? Give me an example, for instance, of a care beyond basic care that you would restrict Medicaid patients to now.

What ought we not to provide Medicaid beneficiaries with today? What is excessive?

Mr. RETTIG. Ideally, we would like to provide basic care, whatever that is, and as adequate care as the Government can fund and that it is found to be useful. But if there are limits on the funding, for example, of the Medicaid program——

Chairman STARK. Which there are.

Mr. RETTIG [continuing]. For low-income people, then the benefits need to be limited in some way. There could be limits in duration. There could be certain types of services not covered.

Chairman STARK. One of our biggest problems in California are poor young women who are pregnant. What care would you limit beyond basic care under the Medicaid program, and which providers would you exempt from having to provide that basic care in the State of California, for example?

Mr. RETTIG. In the first place, let me make clear, in an emergency situation, we are assuming——

Chairman STARK. I am just assuming that a pregnancy without a hospital or a doctor is an emergency, and I am just suggesting that you have a poor woman who is pregnant and is treated in a medical facility in California. What care beyond this so-called basic care would you suggest? Give me an example of the type of care that person might want that you would not provide.

Mr. RETTIG. I am sure I can give you a specific case. I think what I am thinking of and that what the people——

Chairman STARK. Give me a provider that you would suggest ought not be available to this poor person. Kaiser?

Mr. RETTIG. One possibility is that you could have—require people to choose a managed care kind of an arrangement. A system that is designed not only to provide care of adequate quality, but to do it in a cost-effective way, and that would be a way of restricting choice of provider, rather than naming providers to which a person could not get care.

Chairman STARK. That is the same thing, isn't it? If I say you have to go to Kaiser, and that is the only place you can go, I have immediately restricted your ability to go to Highland or Eden or Stanford Medical Center, haven't I?

Mr. RETTIG. That is correct.

Chairman STARK. Are you suggesting that for people who are in the public program, they should be restricted, say, to the veterans' hospitals or to the military hospitals, or to some particular system and not be allowed to get into the general provider care system?

Mr. RETTIG. That is a possibility, although as we develop our plan, we may not recommend that at all.

Chairman STARK. Now, give me an idea of what you mean by care beyond basic care. Give me an example, please.

Mr. RETTIG. It is very hard for me to do, because I said earlier, we are still in the process of defining basic care, and among the people discussing it there are those who think it means everything except cosmetic surgery.

Chairman STARK. I would spot you cosmetic surgery for another year or two, for all men under 50. But——

Mr. RETTIG. There are others who think the basic benefits package needs to be fairly restrictive in order for society to afford——

Chairman STARK. Let me give you another example. In what areas does your hospital association consider they have been a problem? What kind of excessive care have the members of the American Hospital Association had to provide beyond basic care that has caused them concern?

Mr. RETTIG. I don't think it is a question of excessive care, although there are a lot of optional choices people make.

Chairman STARK. What optional choices have been fostered upon members of your association, say, antidumping or other laws in various States that have caused them concern?

Mr. RETTIG. None that I know of in the antidumping area.

Chairman STARK. Any area?

Mr. RETTIG. I don't think it is optional services being pushed upon us, we are trying to recognize the reality that people with additional money are going to have richer insurance packages, and the Government may not be able to afford such packages, and if so, any limits should be explicit, rather than assuming all services of every kind are covered.

Chairman STARK. Well, I guess I made my point. I hope that the next time I see your many points, that your association will have had a lot of time to think about restricting benefits or choices to poor people.

I am sure that wasn't based on Dr. Sullivan's comments of yesterday, but it seems to me if we are starting out to help poor people in this operation, we could be a little more generous at the outset.

Mr. RETTIG. We are not prepared to say that something like the State of Oregon is doing in Medicaid is appropriate, but we are saying people should think explicitly what to do when there is not funding to do everything everybody would like.

Chairman STARK. Mr. Coyne.

Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I don't have any questions. I wonder if——

Chairman STARK. I sort of got out of line, ahead, of letting the rest of the panel finish.

Mr. PICKLE. Let's proceed with the panel.

Chairman STARK. Thank you. I apologize to the panel for interrupting the normal ebb and flow of the testimony and questioning.

Mr. Foley, we have got you second. Why don't you proceed?

STATEMENT OF EDWARD J. FOLEY, CHAIRMAN OF THE BOARD, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, AND ADMINISTRATOR, LOS ANGELES COUNTY/HARBOR UCLA MEDICAL CENTER

Mr. FOLEY. Mr. Chairman, members of the committee, I am Ed Foley, administrator, Los Angeles County/Harbor UCLA Medical Center, and chairman of the board of the National Association of Public Hospitals. NAPH consists of 90 public and nonprofit teaching hospitals serving as major tertiary referral centers for the poor in most of our Nation's largest metropolitan areas.

I am pleased to have the opportunity this morning to comment on the impact of current health insurance policy, or lack thereof, on our Nation's urban safety net hospitals. This is especially timely since HHS Secretary Sullivan said yesterday there can be no national health program. He is wrong, as you are hearing this morning.

In my brief statement this morning, I hope to accomplish one goal. I hope to make this committee aware of the enormous and increasing financial pressure on these safety net hospitals, and the State and local governments that support them, resulting from our Nation's shameful failure to enact some form of national health insurance coverage.

First, let me tell you a little bit about the hospital where I work. Harbor is the second largest of the six hospitals operated by the county of Los Angeles. It has 553 licensed beds, admits 90 patients per day, sees 330 patients per day in the emergency room, and provides 875 patient visits per day in the outpatient department.

When I came to Harbor in 1981, the average number of inpatients was 375. For the past 3 years, the number has been over 475. On the financial side, the hospital has been, and continues to be, pressured. The increase in the number of uninsured patients has squeezed out most of the patients with private insurance or Medicare; formerly, this group totaled nearly 20 percent. Now it is below 5 percent.

We have a fairly new building. It opened 27 years ago, in 1963. There have been no significant alterations and no additions to the building since that time. The hospital is resource-starved both in capital and in operations. The annual depreciation amount is less than three-quarters of 1 percent.

The annual budget for equipment is less than one-half of what is typically spent in other hospitals of equivalent size. The cost per day at the hospital is $802 per day compared to the average cost per day of all hospitals in California of $1,100.

Other than direct support from the County of Los Angeles and the State of California, the hospital's main income is from the Medicaid program. Many patients coming to Harbor have never been served by a public hospital; they had always been covered by insurance in the past. Some people qualify for Medicaid; many do not. Here are two typical examples of patients we have served this year:

Mary Ann Samuels is a 44-year-old woman who had a cancerous lump removed from the breast in April 1990. She is now undergoing chemotherapy and radiations. She expects to return to work this fall. Mary is divorced and has successfully raised two children to adulthood. She was working full time as an office worker through a temporary agency and therefore had no health insurance. Her goal is to get well and then get a permanent job where she could get health insurance benefits.

Peggy O'Halloran is an HIV-positive, married woman with three children. Her current husband is a recovered drug user. At the time of their marriage, they were unaware he was HIV-positive. He was recently diagnosed with AIDS. Both the husband and wife were outpatients at Harbor-UCLA.

Because of his illness he was unable to continue as a construction worker, and therefore lost all health insurance. Peggy's husband takes care of the children while she works in the cosmetic section of a department store, but she receives no health insurance benefits.

These examples are not unique. They point up the need for national health insurance.

First, it is essential to understand that the only reason we have had the luxury of debating rather than enacting universal health insurance is the existence of an institutional health safety net, a small number of public hospitals dedicated to the care of the uninsured.

This safety net is comprised of no more than 200 to 300 public and nonprofit hospitals, mostly in metropolitan areas. The condition of these safety net providers has deteriorated in recent years, and is far worse today than when universal health coverage was last debated.

Let me illustrate this point with a few facts about safety net hospitals and their uninsured patients:

Safety net hospitals are bursting at the seams. Fifty-five NAPH member hospitals across the Nation averaged an 81-percent occupancy rate in 1988.

Many of the patients in safety net hospitals are uninsured, even by Medicaid; in 1988, nearly 34 percent of all discharges and 29

percent of all inpatient days were unsponsored in NAPH member hospitals; 52 percent of all outpatient visits were also uninsured.

Just 17 percent of the net revenues of safety net hospitals are derived from private insurance, while 50 percent of revenues come from Medicaid and direct State/local subsidies; half of NAPH member hospitals experience deficits averaging 6.2 percent of net operating revenue.

The growth and persistence of these deficits have been exacerbated in recent years by new epidemics concentrated on the poor and disenfranchised, including AIDS, drug abuse, neonatal problems, and inner city violence.

The ability of safety net hospitals to cope with these new epidemics and still serve their other patients is further affected by critical manpower shortages and the inability to obtain capital for renovation, maintenance and technology.

Nearly half of 23 trauma centers designated 3 years ago in Los Angeles have now closed their trauma units, leading to serious overcrowding in the rest of the system; over 50 percent of the emergency room and trauma care delivered in urban public hospitals nationally is for uninsured patients. The L.A. County Health Department provides OB services for every 93d baby born in the United States.

Obstetric units are also crowded to overflowing. At my hospital, we must now discharge obstetric patients just 12 hours after giving birth, and their babies after just 24 hours, to make room for other patients. Some mothers leave after 3 or 4 hours because it is better to be at home than on a chair at Harbor-UCLA. Last year, 8,800 babies were born in Harbor's OB unit, which is designed and staffed for only 5,000 births.

Given the crisis facing the uninsured and the hospitals which serve them, it is imperative that Congress develop and enact national health insurance legislation. NAPH is currently working to develop concrete proposals in this regard, and we expect to have completed our work later this year.

In the meantime, and in light of the history of debate regarding universal health coverage, we strongly urge this committee to move ahead with appropriate incremental approaches.

One: Congress must move quickly to expand employee-based health insurance coverage.

Two: Congress should adopt measures to increase the inadequate Medicaid eligibility levels and payment rates, and specifically, Congress should require States to provide meaningful Medicaid disproportionate share payments. NAPH also believes that our current crazy-quilt of Medicaid programs should be replaced by a single national public health plan, with national standards for eligibility, services and payment.

Three: I ask your committee to continue to champion the Medicare disproportionate share hospital adjustment and the Medicare medical education adjustment. A recent Congressional Budget Office study concludes that Medicare disproportionate share payments exceed the costs incurred by DSHs in treating Medicare patients. The reality is that 59 percent of public hospitals surveyed by NAPH had negative operating margins for 1989.

Without a meaningful disproportionate share adjustment, this percentage would have been higher. CBO missed the point entirely. Unless Medicare continues to make an adequate contribution to the overall financial condition of safety net hospitals, our entire health system will face the consequences.

Four: Congress must provide specific help to safety net hospitals if we are to continue to serve trauma patients, AIDS patients, and drug abuse patients.

We commend the chairman for the leadership you have shown in introducing legislation which provides for direct support for safety net hospitals based upon their level of uncompensated care. The enactment of this legislation is also critical to the continued survival of the safety net.

Finally, it is imperative that the Congress work with us to assist safety net hospitals in obtaining access to needed capital for renovations, equipment, new services and rebuilding. Many of our hospitals are shut out of the capital markets, Mr. Chairman, because of the nature of the patients we serve.

We will need assistance to open these doors. NAPH is currently drafting a comprehensive new capital program. We hope to see this proposal introduced before the end of this session and taken up and enacted next year. We appreciate your leadership, Mr. Chairman, in this area as well as your leadership in achieving our overall goal of universal health coverage.

I appreciate the opportunity to testify this morning, and I would be happy to answer any questions which you might have.

Chairman STARK. Thank you, sir.

[The statement of Mr. Foley follows:]

TESTIMONY OF

Ed Foley
Administrator
Los Angeles County/Harbor UCLA Medical Center

Before the Health Subcommittee of the House Ways and Means Committee

ON BEHALF OF

Los Angeles County/Harbor UCLA Medical Center and the National Association of Public Hospitals

July 24, 1990

Mr. Chairman, members of the Committee, I am Ed Foley, Administrator, Los Angeles County/Harbor UCLA Medical Center. I am also Chairman of the Board of the National Association of Public Hospitals (NAPH). NAPH consists of 90 public and non-profit teaching hospitals that serve as major tertiary referral centers for the poor in most of our nation's largest metropolitan areas.

I am pleased to have the opportunity this morning to comment on the impact of current health insurance policy (or the lack thereof) on our nation's urban "safety net" hospitals. In my brief statement this morning, I hope to accomplish one goal. I hope to make this committee aware of the enormous and increasing financial pressure on these safety net hospitals and the state and local government that support them, that results from our nation's shameful failure to enact some form of national health insurance coverage. I hope to make this committee aware of the enormous financial pressure on public hospitals resulting from the lack of national health insurance.

HARBOR-UCLA MEDICAL CENTER

First, let me tell you a little bit about the hospital where I work. Harbor is the second largest of the six hospitals operated by the County of Los Angeles. It has 553 licensed beds, admits 90 patients per day, sees 330 patients per day in the emergency room and provides 875 patient visits per day in the outpatient department. When I came to Harbor in 1981 the average number of inpatients was 375. For the past three years the number has been over 475. On the financial side, the hospital has been and continues to be pressured. The increase in the number of uninsured patients has squeezed out most of the patients with private insurance or Medicare. Formerly this group totalled nearly twenty percent. Now it is down below five percent.

We have a fairly new building. It opened 27 years ago in 1963. There have been no significant alterations and no additions to the building since that time. The hospital is resource starved in capital and in operations. The annual depreciation amount is less than three quarters of one percent. The annual budget for equipment is less than one half of what is typically spent in other hospitals of equivalent size. The cost per day at the hospital is $802 per day compared to the average cost per day of all hospitals in California of $1,100. Other than direct support from the County of Los Angeles and the State of California the hospital's main income is from the Medicaid program. Many patients coming to Harbor have never been served by a public hospital. Before, they were covered by insurance. Some of these qualify for Medicaid, many do not. Here are two typical examples of patients we have served this year:

> Mary Ann Samuels is a 44 year old woman who had a cancerous lump removed from the breast in April 1990. She is now undergoing chemotherapy and radiations. She expects to return to work this Fall. Mary is divorced and has successfully raised two children to adulthood. She was working full time as an office worker through a temporary agency and therefore had no health insurance. Her goal is to get well and then get a permanent job where she could get health insurance benefits.
>
> Peggy O'Halloran is an HIV positive, married woman with three (3) children. Her current husband is a recovered drug user. At the time of their marriage, they were unaware he was HIV positive. He was recently diagnosed with AIDS. Both the husband and wife are out-patients at Harbor-UCLA. Because of his illness he was unable to continue as a construction worker and therefore lost all health insurance. Peggy's husband takes care of the children while she works in the cosmetic section of a department store but receives no health insurance benefits.

The failure to provide universal health coverage and access to care has for years been the single most important issue facing our nation's health system. It has also been one of the most important social, economic, and ethical problems facing all Americans -- and unfortunately, one of the most controversial as well. In the last twenty years, there have been at least a dozen major national health insurance initiatives as well as scores of more modest proposals. Each of these has generated influential opposition, virtually paralyzing efforts to achieve needed reform. In the 1980s, the onset of Reaganomics and a growing budget deficit eclipsed all but the smallest incremental efforts at improvement. As a

result, despite the fact that almost everyone agrees that universal coverage is the very foundation of a humane and civilized society, we have advanced very little in this arena since the passage of Medicare and Medicaid in the 1960s.

For this reason, we face a health care crisis in America today, which affects not only uninsured patients and the hospitals that serve them, but also our entire health system. The need for immediate action can be underscored by looking at the gravity of this crisis.

First, it is essential to understand that the only reason we have had the luxury of debating rather than enacting universal health insurance is the existence of an institutional health "safety net," a small number of public hospitals dedicated to the care of the uninsured. This safety net is comprised of no more than two to three hundred public and nonprofit hospitals, mostly in metropolitan areas. Second, the condition of these safety net providers has deteriorated in recent years, and is far worse today than when universal health coverage was last debated. Let me illustrate this point with a few facts about safety net hospitals and their uninsured patients:

- Safety net hospitals are bursting at the seams, providing an extraordinary volume of inpatient and outpatient care. NAPH members provided, on average, over 200,000 outpatient visits, 18,000 inpatient admissions, and 3,500 live births in 1988. In comparison, short-term acute care hospitals nationally averaged only 5,619 admissions per hospital.

- 55 NAPH member hospitals across the nation averaged an 81% occupancy rate in 1988, with many hospitals approaching 100%.

- Many of the patients in safety net hospitals are uninsured, even by Medicaid; in 1988, nearly 34% of all discharges and 29% of all inpatient days were unsponsored in NAPH member hospitals; over 47,000 outpatient visits on average, or 52% of all visits, were also uninsured.

- Just 17% of the net revenues of safety net hospitals are derived from private insurance, while 50% of revenues come from Medicaid and direct state/local subsidies (an average of $37 million in Medicaid revenues and $27 million in direct subsidies); without direct subsidies, NAPH member hospitals would average operating deficits of over 25% -- and even with subsidies, over half still experience deficits averaging 6.2% (or nearly $8 million).

- For some safety net hospitals, these proportions are far higher. For San Francisco General Hospital, unsponsored care represented 62% of all inpatient days and 72% of all outpatient visits in 1988; for Dallas' Parkland Memorial Hospital, the figures were 54% of inpatient days and 62% of OPD visits.

- The growth and persistence of these deficits have been exacerbated in recent years by new epidemics concentrated on the poor and disenfranchised, including AIDS, drug abuse, neonatal problems, and inner city violence. And the ability of safety net hospitals to cope with these new epidemics and still serve their other patients is further affected by critical manpower shortages and the inability to obtain capital for renovation, maintenance and technology.

- These new epidemics, combined with the general lack of availability to the uninsured of preventive health services, means that safety net patients are also more likely to be sicker than insured patients -- especially inner city minorities. The New England Journal of Medicine reported last year that black men in Central Harlem now have a lower life expectancy than men in Bangladesh. And here in Washington, D.C., a resident of Anacostia is ten times more likely to require hospitalization for pneumonia than a resident of Georgetown.

- There are today 2,000 AIDS patients in New York City hospital beds. This total is projected to rise to 4,000 by 1993 or 1994. Yet there are fewer staffed beds in New York today than in 1985, and inadequate funding for treatment alternatives.

- Nor are these problems limited to New York and California -- they affect middle America as well. For example, 15% of all babies born at Kansas City's Truman Medical Center last year had traces of cocaine in their blood.

- Nearly half of 23 trauma centers designated three years ago in Los Angeles have now closed their trauma units, leading to serious overcrowding in the rest of the system; over 50% of the emergency room and trauma care delivered in urban public hospitals nationally is for uninsured patients. In California, we have taxed cigarettes to help pay for trauma and emergency room costs. The LA County HEalth Department provides OB services for every 93rd baby born in the United States.

- Obstetric units are also crowded to overflowing; at my hospital, we must now discharge obstetric patients just twelve hours after giving birth, and their babies after just 24 hours, to make room for other patients. Some mothers leave after 3 or 4 hours because it is better to be at home than on a chair at Harbor-UCLA. Last year 8,800 babies were born in Harbor's OB unit which is designed and staffed for only 5,000 births.

- The single highest volume provider of AIDS services in the entire nation is not in New York or California -- it is Miami's Jackson Memorial Hospital, which had over 1000 AIDS admissions in 1988.

Immediate Solutions are Needed

Given the crisis facing the uninsured and the hospitals which serve them, it is imperative that Congress develop and enact national health insurance legislation. NAPH is currently working to develop concrete proposals in this regard and we expect to have completed our work later this year. In the meantime and in light of the history of debate regarding universal health coverage, we strongly urge this Committee to move ahead with appropriate incremental approaches.

First, Congress must move quickly to expand employee-based health insurance coverage. While we are aware that Medicaid is not in the jurisdiction of your committee, it is also imperative that Congress adopt measures to increase inadequate Medicaid eligibility levels and payment rates. In this regard, Congress should require states to provide meaningful Medicaid disproportionate share payments. NAPH also believes that our current crazy quilt of Medicaid programs should be replaced by a single national public health plan, with national standards for eligibility, services and payment.

Second, while we are debating these incremental proposals, you and your Committee must protect the existing safety net. You and your Committee have been important champions of the Medicare disproportionate share hospital adjustment and the Medicare medical education adjustment. A recent Congressional Budget Office study concludes that Medicare disproportionate share payments exceed the costs incurred by DSHs in treating Medicare patients. The reality is that 59% of public hospitals surveyed by NAPH had negative operating margins for 1989. Without a meaningful disproportionate share adjustment, this percentage would have been higher. CBO missed the point entirely. Unless Medicare continues to make an adequate contribution to the overall financial condition of safety net hospitals, our entire health system will face the consequences.

Third, Congress must address the special needs of safety net hospitals and craft programs that will allow them to fulfill their special mission. For example, trauma centers continue to close and the number of AIDS patients and drug abuse patients continues to rise. Public hospitals must have help in these specific areas if they are going to continue to serve these expanding populations.

In addition, we commend the Chairman for the leadership you have shown in introducing legislation which provides for direct support for safety net hospitals based upon their level of uncompensated care. The enactment of this legislation is also critical to the continued survival of the safety net.

Finally, it is imperative that the Congress work with us to assist safety net hospitals to obtain access to needed capital for renovations, equipment, new services, and rebuilding. Many of our hospitals are shut out of the capital markets, Mr. Chairman, because of the nature of the patients we serve. We will need assistance to open these doors. NAPH is currently drafting a comprehensive new capital program. We hope to see this proposal introduced before the end of this session and taken up and enacted next year. We appreciate your leadership, Mr. Chairman, in this area as well as your leadership in achieving our overall goal of universal health coverage.

I appreciate the opportunity to testify this morning and I would be happy to answer any questions which you might have.

Chairman STARK. Sister Mary Roch Rocklage.

STATEMENT OF SISTER MARY ROCH ROCKLAGE, R.S.M., FORMER CHAIRPERSON, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, CHAIRPERSON, SELECT COMMITTEE ON INDIGENT CARE, AND CHIEF EXECUTIVE OFFICER, SISTERS OF MERCY HEALTH SYSTEMS, ST. LOUIS, MO.

Sister ROCKLAGE. Good morning, Mr. Chairman and members of the subcommittee.

I am Sister Mary Roch Rocklage, chief executive officer of the Sisters of Mercy Health System—St. Louis, a Catholic health care system comprised of 14 hospitals and three long-term care facilities in 7 States. I am a former chairperson of the Catholic Health Association of the United States, whose membership includes more than 900 hospitals and long-term care facilities nationwide. Presently, I chair CHA's Select Committee on Indigent Care.

At the outset of my testimony, Mr. Chairman, I want to acknowledge and commend your subcommittee's continuing attention to the pressing need to achieve universal access to health care services in the United States. Likewise, I commend you, Mr. Stark, for crafting the MediPlan proposal and for introducing H.R. 4280 as the first step in implementing universal access. For the past decade, the U.S. political environment has not been conducive to the pursuit of such a goal. Today, however, the increasing dissatisfaction with the dysfunctional character of our health care system has resulted in an emerging consensus about the need for universal access and systemic health care reform. Thus, we appear to be on the verge of a national debate on how best to achieve a program of national health insurance in the United States.

Today's hearing is both important and timely.

Mr. Chairman, CHA's public policy position on national health care reform flows out of the following six observations and beliefs:

One, the U.S. health care system's many inefficiencies have resulted in the paradoxical and untenable situation whereby it is annually much more expensive but also it annually meets the health care needs of fewer members of our society.

Two, the pressing need to control the costs of our health care system while improving its quality and accessibility cannot be achieved by incremental means. It is time to embrace comprehensive system reform that includes universal access.

Three, the need to achieve universal access to adequate health care services will not be fully addressed until society commits itself to making insurance available to all persons.

Four, although Catholic and other providers and various levels of government should work toward equitable access to health care services, the Federal Government bears the ultimate responsibility for ensuring that this obligation is met.

Five, it is an important tenant of Catholic social teaching that access to adequate health care services is necessary for the development and maintenance of life. Achieving universal access is, therefore, the Catholic Health Association's highest public policy priority.

Six, the formulation of any program of national health insurance should be guided by certain general principles which are adopted after a national debate.

The phrase "national health insurance," as used by CHA in this testimony, is not meant to refer to any specific program or proposal. Nor is the association presently prepared to endorse any of the major reform proposals which have been put forth over the past year. Rather, CHA means the phrase generically to refer to any arrangement for the financial pooling of health care risks that provides basic health insurance coverage to all persons in the United States and is operated at least in part by the Federal Government. By the phrase "at least in part" we mean that the State and local governments, as well as private insurers and employers, may play key roles in financing and administering such a national program.

Thus, for CHA, national health insurance does not have just one meaning or definition. Alternative models abound worldwide. Nevertheless, for CHA, the essence of national health insurance is the responsibility for and the use of the authority of the Federal Government to arrange for equitable and universal health insurance.

CHA has initiated its own internal process for formulating by early spring of 1991 a set of recommendations on the future organization, financing and delivery of health care in the United States. This process is called the CHA National Health Policy Project. The project comprises three separate but closely related elements.

One, the first element was a year-long process which resulted in the formulation of a set of principles for systemic health care reform. The CHA Board of Trustees endorsed the principles this past April.

The nine principles will guide CHA and its members with regard to its advocacy of a national health insurance program.

Briefly described, the CHA principles for systemic health care reform: (*a*) emphasize the shared responsibility of all segments of our society; (*b*) acknowledge the necessary and appropriate role of Government in fashioning systemic health care reform; (*c*) proclaim the Catholic health care ministry's support for universal access, freedom of conscience, and public accountability; (*d*) insist on prudent stewardship of scarce resources; (*e*) encourage equity in both the financing and the reimbursement of the delivery of health care services; and (*f*) challenge Catholic care givers to be advocates for the health care poor.

I refer members of the subcommittee to my written testimony in which the exact wording and interpretation of the principles are thoroughly described.

The second element of CHA's National Health Policy Project is a series of regional membership meetings this fall at which major proposals for health care reform will be evaluated with respect to their likely mission and operational/financial impact on Catholic health care providers.

The third element is a yet to be designed advocacy effort which will attempt to focus public opinion on the need for systemic reform and thereby encourage the Nation's political leaders to make it a priority.

In conclusion, the establishment of a program of national health insurance is a test of our national character and political will. It is

likewise an opportunity for the United States to join the rest of the industrialized democracies in eliminating the suffering, unfairness and indignity of medical indigency.

Mr. Chairman, I again commend the subcommittee for the determination it has demonstrated in these six hearings to identify solutions to the access problems in our health care system.

The Catholic Health Association pledges to work with you and others to effect universal access in the context of meaningful health care reform.

Thank you.

[The statement of Sister Rocklage follows:]

STATEMENT OF SISTER MARY ROCH ROCKLAGE, RSM
THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Good morning, Mr. Chairman and members of the Subcommittee.

I am Sister Mary Roch Rocklage, a Sister of Mercy of the Union and the Chief Executive Officer of the Sisters of Mercy Health System - St. Louis, a Catholic healthcare system comprised of 14 hospitals and three long-term care facilities in seven states. I am a former Chairperson of the Catholic Health Association of the United States (CHA) whose membership includes more than 900 hospitals and long-term care facilities nationwide. Presently, I chair CHA's Select Committee on Indigent Care.

At the outset of my testimony, Mr. Chairman, I want to acknowledge and commend your Subcommittee's continuing attention to the pressing need to achieve universal access to healthcare services in the United States. For the past decade, the U.S. political environment has not been conducive to the pursuit of such a goal. Today, however, the increasing dissatisfaction with the dysfunctional character of our healthcare system has resulted in an emerging consensus about the need for universal access and systemic healthcare reform. Thus, we appear to be on the verge of a national debate on how best to achieve a program of national health insurance in the United States. Today's hearing is both important and timely.

CHA Policy Position

Mr. Chairman, CHA's public policy position on national healthcare reform flows out of the following observations and beliefs:

- The U.S. healthcare system's many inefficiencies have resulted in the paradoxical and untenable situation whereby it is annually much more expensive but also it annually meets the healthcare needs of fewer members of our society.

- The pressing need to control the costs of our healthcare system while improving its quality and accessibility cannot be achieved by incremental means. It is time to embrace comprehensive system reform that includes universal access.

- The need to achieve universal access to adequate healthcare services will not be fully addressed until society commits itself to making insurance available to all persons.

- Although Catholic and other providers and various levels of government should work toward equitable access to healthcare services, the federal government bears the ultimate responsibility for ensuring that this obligation is met.

- It is an important tenant of Catholic social teaching that access to adequate healthcare services is necessary for the development and maintenance of life. Achieving universal access is, therefore, the Catholic Health Association's highest public policy priority.

- The formulation of any program of national health insurance should be guided by certain general principles which are adopted after a national debate.

National Health Insurance

The phrase "national health insurance," as used by CHA in this testimony, is not meant to refer to any specific program or proposal. Nor is the Association presently prepared to endorse

any of the major reform proposals which have been put forth over the past year. Rather, CHA means the phrase generically to refer to any arrangement for the financial pooling of healthcare risks that provides basic health insurance coverage to all persons in the United States and is operated at least in part by the federal government. By the phrase "at least in part" we mean that the state and local governments, as well as private insurers and employers, may play key roles in financing and administering such a national program. Thus, for CHA, national health insurance does not have just one meaning or definition. Alternative models abound worldwide. **Nevertheless, for CHA, the essence of national health insurance is the responsibility for and the use of the federal government to arrange for equitable and universal health insurance.** [1]

Is The Environment Changing?

CHA believes that a restructuring of the healthcare system is not only desirable but may, in fact, be possible in the near future. Respected national journals and newspaper editorials are inundating their readers with opinions and articles on the need to reform the nation's healthcare system. On Capitol Hill, a growing number of members of Congress, on both sides of the aisle, are calling for systemic healthcare reform. In 1989, six major public policy proposals were developed to provide all Americans with health insurance. In addition to the Chairman's MediPlan proposal and the introduction of his bill, H.R. 4280, as the first step in ensuring universal access, at least three others have been put forth already this year. Although some of these proposals markedly different means to achieve reform, they all seek significant changes in the U.S. healthcare system. At the state level, the National Governors' Association has established a committee to work with Congress to design a more rational system. Importantly, major corporations are entering the debate for the first time, some calling for the creation of a national health insurance program. Finally, public opinion polls indicate that Americans are significantly less happy with their healthcare system than either the British or the Canadians are with theirs. In one poll, 89 percent of the respondents said that the U.S. healthcare system was in need of either fundamental change or complete rebuilding. A public consensus is forming that the U.S. healthcare system, the most advanced and sophisticated in the world, is in need of fundamental reform.

This emerging consensus provides the public support necessary for this Subcommittee and the larger Congress to search determinedly for answers to the following serious questions:

- How do we fix a system which consumed $600 billion last year and may devour twice that amount in the next four years?
- How do we repair a system in which the more dollars we spend on healthcare the more uninsured Americans there are?
- How do we mend our healthcare safety net which presently allows at least 63 million Americans, a quarter of the population, to fall through because they lack steady health insurance?
- How do we salvage a system in which there is uncertainty as to whether patients are always being well served and whether the costs are commensurate with the benefits?

[1] Charles J. Dougherty, "The Moral Case for National Health Insurance," in Biomedical Ethics Reviews: 1990 (in press).

- How do we preserve and encourage what is good in the present system while we address its deficiencies?

CHA's National Health Policy Project (NHPP)

CHA has initiated its own internal process for formulating by early spring of 1991 a set of recommendations on the future organization, financing and delivery of healthcare in the United States. This process is called the CHA National Health Policy Project (NHPP). The project comprises three separate but closely related elements:

I. Guiding Principles for Reform

The first element is a process which was initiated and directed by the CHA Select Committee on Indigent Care whereby the membership of the Association, as well as representatives from other national Church agencies, had the opportunity not only to contribute to CHA's health policy direction, but also to shape a Catholic leadership position on systemic healthcare reform. The year-long process resulted in the formulation of a set of Principles for Systemic Healthcare Reform which the CHA Board of Trustees endorsed three months ago.

The nine Principles will guide the Catholic Health Association and its members with regard to its advocacy of a national health insurance program.

Briefly described, the CHA Principles for Systemic Healthcare Reform: a) emphasize the shared responsibility of all segments of society as they acknowledge the necessary and appropriate role of government in fashioning systemic healthcare reform; b) proclaim the Catholic healthcare ministry's support for universal access, freedom of conscience, and public accountability; c) insist on prudent stewardship of scarce resources; d) encourage equity in both the financing and the reimbursement of the delivery of healthcare services; and lastly, e) challenge Catholic caregivers to be advocates for the healthcare poor.

Prefaced by a faith statement as context in which they must be interpreted, the Principles for Systemic Healthcare Reform are:

1. **UNIVERSAL ACCESS**

Access to those healthcare services necessary for the development and maintenance of life is a basic human right.

2. **BASIC COMPREHENSIVE BENEFITS**

The federal government must determine a basic level of healthcare services sufficiently comprehensive to promote good health, to provide appropriate treatment for persons with disease and disability, and to care for persons who are chronically ill or dying.

3. **SHARED RESPONSIBILITY**

The protection, promotion, maintenance, and enhancement of health is a responsibility shared by individuals and families, private businesses and organizations, voluntary agencies and government. In addition, government at all levels is primarily responsible for preventing or correcting situations that threaten the health of the population.

4. FREEDOM OF CONSCIENCE

The right of all parties to the free exercise of their ethical and religious beliefs must be protected in public healthcare policy.

5. USE AND ALLOCATION OF RESOURCES

The healthcare system must include:

- allocation of healthcare resources on the basis of community needs;
- incentives to individuals to practice good health;
- effective measures for ensuring appropriate utilization of services;
- adequate, equitable, timely, and predictable payments to healthcare providers;
- promotion of the efficient and cost-effective use of facilities, equipment, and services;
- provision for support of research, education, and training; and
- standards by which these objectives can be measured.

6. PUBLIC ACCOUNTABILITY

Public policy must ensure broad community participation in identifying healthcare needs, in establishing priorities, in determining basic comprehensive benefits, and in creating standards and mechanisms for assessing the healthcare system's responsiveness to these priorities.

7. QUALITY ENHANCEMENT

Public healthcare policy must ensure that processes and standards are established and used for evaluating and improving outcomes and ensuring the appropriateness of health services.

8. FINANCING

Financing the delivery of basic comprehensive healthcare services is a societal obligation. The federal government must ensure that a financing mechanism, imposed on individuals, organizations, and governmental units, will be based on an equitable and progressive formula.

9. ADMINISTRATION

The structure and regulations for the administration of the healthcare system must be simple, coherent, responsive, and cost-effective and must be monitored and evaluated on a timely basis.

II. Regional Membership Meetings

The second NHPP element is a series of fall 1990 regional membership meetings at which major proposals for healthcare reform will be evaluated with respect to their likely mission and operational/financial impact on Catholic healthcare providers.

III. Advocacy

The third element of CHA's National Health Policy Project is a yet to be designed advocacy effort which will attempt to focus public opinion on the need for systemic reform and thereby encourage the nation's political leaders to make it a priority.

Conclusion

In conclusion, the emerging debate with regard to systemic healthcare reform is a challenge to redirect our national efforts and resources into a social program that will significantly help millions of our fellow citizens.

The establishment of a program of national health insurance is a test of our national character and political will. It is likewise an opportunity for the United States to join the rest of the industrialized democracies in eliminating the suffering, unfairness and indignity of medical indigency.

Mr. Chairman, I again commend the Subcommittee for the determination it has demonstrated in these six hearings to identify solutions to the access problems in our healthcare system.

The Catholic Health Association pledges to work with you and others to effect universal access in the context of meaningful healthcare reform.

Chairman STARK. Thank you, Sister. I want to try this: I have suggested earlier today in proposed legislation that we use Medicare as a model, at least as an outline for discussion. It has a set of benefits. It has a set of payments, it has a way to finance it. It has a way to administer it and we all know what it is. We can change it but it is a little easier than inventing a new system.

I have suggested that any universal health care package ought to have three basic tenets. Every resident in the country ought to have medical care available to them. Call that insurance, if you will. Every provider ought to have the right to expect a reasonable compensation. Not necessarily desired, but reasonable compensation for the services or products provided and we all ought to pay for it in some kind of progressive manner.

Now, if you applied Medicare to all hospitals, arguably if that became the national health insurance system, and we got away from Medicaid and Blue Cross and Aetna, everybody would have coverage. The effect on hospitals, I submit, would be OK. I have some figures from California, and I would just like the opinions of the witnesses.

Basically if you add unreimbursed Medicare costs, you all know what we refer to there and if you add back unreimbursed Medicaid costs, you get a total unreimbursed Medicare/Medicaid cost of $962 million for the State of California.

Now, if you add bad debt and sharing care cost for the entire State you get $1.2 billion. What I am going to suggest is if hospitals in California were paid Medicare rates for Medicaid and for all bad debt and charity care, they would come out ahead by $324 million.

Now each of you might think about how your hospital would win or lose, but my guess is that if you then knock out whatever the overhead costs or whatever the overhead savings would be by having a single payer, then hospitals would probably do all right if everybody that walked through the door paid at a Medicare rate.

Do you want to comment on that? That is just an assumption. How would the Catholic hospitals do on that, Sister? What is your guess? I am not going to hold you to it.

Sister ROCKLAGE. I think if we looked at it from a quick fix point of view, my initial reaction might be yes, that sounds good financially. But I would not at this point want to endorse a short-term solution as the way to go.

To your questions earlier, Mr. Stark, my response would be rather than to start solving the access problem with the Medicare program which we know and are comfortable with, we ought to step back and look down the road, 10, 15 years and ask what would be the best way to structure the solution to meet the needs of our society.

It is possible that we could answer the question by using Medicare as a guideline for a solution, but at least we could not have started with a narrow approach.

Chairman STARK. Sister, you come from an institution that is even older than the one I represent by 1,800 years if my arithmetic is right, and you know how rapidly institutions change.

I would agree with you. I think the one thing I have learned, if we try and change anything too much we get resistance we didn't

believe was possible. So one of the things I have sort of thought we ought to leave alone is the delivery system.

Now there is no question there could be great improvements in it, but my mother isn't going to happily be directed to one hospital. I tried to get her to go to Kaiser. She didn't want to. She has her doctor. She has always had her doctor. The care she gets is provided by a bunch of doctors she has never heard of in her life, but recommended by this doctor she has. I am just suggesting that in order to make that incremental change, let's get them the money to pay for the services first.

Now, having said that, I only use Medicare because I am most familiar with it, and also our committee won't be able to have hearings if I didn't do it through the Medicare system, but I will spot you Blue Cross. It seems to me if we take some institutions and procedures we are familiar with, and then fill in the blanks we could get further.

I will take Medicaid if you want to, and we can improve that and scrap Medicare. I sense we don't need two or three systems, because I rather think there is some efficiencies in the single payer. I think everybody would agree if that payer were reimbursed at a level high enough they would like it. I think your answer is right. In the short run for most hospitals, if they switched today and got Medicare for every procedure, it would be OK.

Sister ROCKLAGE. I will make one more comment. The quick fix solution now is not going to strengthen us for the future and we are going to be back in the same problem we are in now.

Even if we start off by changing the system with incremental steps, CHA believes we have to have a vision where we want to go, what we want the U.S. health care system to look like.

Chairman STARK. You haven't heard of my painting plan?

Sister ROCKLAGE. Paint by number.

Chairman STARK. All you have to decide is whether it is going to be Monet or Renoir, we get the little outlines. Next year we get the lavender, as long as we are always looking at that picture, OK. That is the Stark incremental plan.

Sister ROCKLAGE. One last comment. I testified 10 years ago before Senator Dole on the issue of national health insurance. Today, we are still talking about it. If we don't do something comprehensively to solve the problems in our health care system, we will be at it another 10 years.

Chairman STARK. That is what I said. That is how we got the number 5300 for the bill.

Mr. Foley, how would you at Harbor Medical Center make out if you got Medicare for everybody that walked in the door?

Mr. FOLEY. Medicare is just about our best payer at the hospital, so that would certainly be a quick fix.

I agree with the concept to have a total vision and begin to work towards it. However, we only have about 3 percent of our patients at my hospital receiving Medicare, and frankly, most of those are crossovers with the Medicaid program.

Medicare still is our best source of income on a per patient basis, and it is one of the things that saves the hospital. We therefore see it as very important.

To have an incremental program that would bring Medicare coverage for all our patients would be certainly a fix at least in the short run.

Chairman STARK. How would the other 5,990 members of your organization fair, Paul, under this?

Mr. RETTIG. Clearly some would do quite well. It would be a delight to have no more unsponsored care.

Chairman STARK. Would any of the not-for-profit hospitals actually lose a lot of revenue?

Sister ROCKLAGE. I couldn't say that. Our contention is that there is some Medicare underpayments.

Chairman STARK. No question. I understand that. I am just saying if Medicare were to absorb all of a sudden all the uncompensated care and bad debts and charity care——

Mr. RETTIG. Clearly, in most cases it would be very helpful. Then the question is what the long term is, whether the adequacy, if it was there at the moment, would continue, and so forth.

Chairman STARK. I think it is not a good system, but to the extent it pays some care.

Is there any reason that poor people should not just be part of one national system so that you as hospital administrators are assured of being reimbursed for the services you provide.

Is there any reason that you should have a two-tier system, one for poor people, and one for otherwise insured people? Sister?

Sister ROCKLAGE. Mr. Stark, if our society really believed that everyone should have access to health care based on the dignity of the human person, then, the ability to pay should not be a consideration.

Part of the problem is that many of us that are involved in developing laws and putting together programs such as Medicaid are not impacted or affected by the programs. I think everyone should have the same coverage so that when the laws are made I know I am covered and I stand at risk equally as much as everyone else. A marketplace economy does not do that.

Chairman STARK. Mr. Foley, would it trouble you that you might be discriminated against at Harbor Medical Center and under Mr. Rettig's plan he might decide your hospital could not be chosen by Medicaid beneficiaries and they would all have to go to Zion?

Mr. FOLEY. I guess I am not troubled because it would be the other way around, and we would be the ones identified to take care of the poor people. I would be troubled by a system that would arbitrarily assign people to hospitals and thereby change the level of care they would be receiving.

Chairman STARK. Can either of you two think of any procedures of basic care that we ought not to provide to low income people that we do provide to others?

Mr. FOLEY. Not really. I suppose the cosmetic surgery, but beyond that I really can't think of any. And with the state of hospitals or at least the hospitals I am most familiar with we are far from those kinds of considerations.

Our considerations are just to get the people in the hospital so the physicians can see them, diagnose and treat them.

Sister ROCKLAGE. Mr. Stark, the second of the nine principles CHA has endorsed calls for a basic and comprehensive level of ben-

efits for everyone. We define that level as services sufficiently comprehensive to promote good health, to provide adequate, appropriate treatment for persons with disease and disability, and to care for persons who are chronically ill or dying.

Chairman STARK. Mr. Coyne.

Mr. COYNE. I have nothing further.

Chairman STARK. I want to thank you all.

Paul, I hope you will take the message back to the other 5900 hospitals on this question of kind of a two-tiered system, and I really hope that you all will stay in touch with the committee.

I believe it was Sister Mary Rocklage who alluded to the Blendon study which indicated that 75 percent of Americans do want some kind of national health insurance. They just don't want the Federal Government to have much to do with it. Sister, in your testimony you indicated that 63 million Americans are at risk for not having health insurance. I believe you are referring to the Census data?

Sister ROCKLAGE. Yes.

Chairman STARK. The data indicated that during a 28-month period, there were as many as 63 million Americans who were not protected by health insurance. Referring to 31 or 37 million uninsured does not adequately describe the severity of the problem.

Right now there may be 37 million but a month from now it might be a different 37 million. In a dynamic model we have a far larger number and the number is increasing as major health insurance companies limit benefits, as they get out of the health insurance business.

I am sorry you didn't bring that out in your summary because I think it is important to suggest that this is just a de minimis number of citizens who incidentally are not just the lay men, the disabled and the structurally poor, but also the working poor in this country who we find are less and less without health coverage.

Please go back to the drawing boards. We need more people like yourselves who are willing to dig in and figure out how this can be resolved.

I commend the American Hospital Association for not trying to change the definition of occupancy but trying to change the definition of universal health care, a far more fruitful area for you to point your efforts, Mr. Rettig, and one that I applaud you for.

I thank the panel very much.

The committee is adjourned.

[Whereupon, at 12 noon, the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

RE: Access to Health Care in America

August 1, 1990

Any discussion regarding access to health care in the United States must begin with an acknowledgment of four undisputed facts. It is a fact that our system provides the most sophisticated and effective health care in the world. It is a fact that a key element of the success of our health care system is its reliance on competition and the freedom of choice principle Americans cherish. It is a fact that our system serves the vast majority of America; approximately 213 million or 87% of all Americans enjoy access to health services through public or private insurance. Unfortunately, it is also a fact that our system is imperfect.

Physicians find the most serious flaw in our health care system to be the inaccessibility of health care coverage for some 33 million Americans. Approximately 70% of the uninsured population is comprised of individuals who are employed or a member of an employed person's family. Another 3% is considered uninsurable because of medical conditions, and the remainder of the group is composed of the nation's poor.

The challenge of crafting a solution to the problem of the uninsured has prompted nationwide study and debate in recent years and months. We think it very significant that this debate is being pursued. We applaud this Subcommittee and the many other groups that are addressing the issue, for it is only through a collaborative and open dialogue that the optimal elements to the solution can be identified.

We are very pleased to present to this Subcommittee "Health Access America," the AMA's proposal to improve Americans' access to health care. In developing Health Access America, the AMA grappled with a threshold issue -- what the role of government should be in the delivery of health care. We concluded that government has a responsibility to act as a catalyst to aid the private sector in providing health coverage, and as a guarantor of last resort to assure access to coverage by individuals unable to help themselves.

We believe that maintenance of this private/public partnership in health care is essential for several reasons. It is essential to maintain American health care as the world standard of excellence, a standard we do not believe society is ready to relinquish. It is essential to preserve the freedom of choice in health care that most Americans enjoy and expect, and all Americans deserve. We believe other countries' experience has shown that these fundamental elements of our health care system would not survive in a monolithic, centralized system.

Given our uniquely superior health care system and societal expectations regarding medical technology and freedom of choice, the AMA advocates strengthening -- not abandoning -- our health care system. Accordingly, Health Access America builds upon the strengths of the current system and reforms ineffective elements.

Employment Based Coverage

The cornerstone of Health Access America is expanding access to the over 20 million employed but uninsured by requiring employer based health insurance. We chose this approach, quite simply, because it has worked so well for so many and for so long. Rather than reinventing the wheel, we chose to retain and reinforce this proven element of our current system.

Our plan would phase in a requirement that employers provide coverage to all full-time employees and their dependents. It would abolish pre-existing condition limitations, and expand COBRA coverage to require employers to pay the same premium share paid prior to termination for up to four months. It would also require employers to offer an enrollment period for employees who lose coverage secondary to a family member's loss of coverage.

Cognizant that this requirement could burden large and small employers, Health Access America calls for a series of contemporaneous financial incentives to assist employers in providing health coverage.

- First, our plan would establish a federal incentive for states to develop private nonprofit risk pools. It would also amend the Employee Retirement Income Security Act (ERISA) to require the currently exempt self-insured plans to participate in these risk pools. The risk pools would be required to offer group rates to small businesses (less than 25 employees), and would provide coverage to the uninsurable population and others who do not have access to group coverage.

- Second, Health Access America would preempt state mandated benefit laws for employer health benefit plans to reduce the myriad state requirements that currently are imposed upon health policies and that clearly inflate costs. Federal legislation would establish the minimum benefits that employer plans would be required to provide. Employers and individuals would be free to purchase additional coverage.

- Third, Health Access America would equalize tax incentives between employers and the self-employed by making permanent and expanding from 25% to 100% the current deduction allowed the self-employed for paid health benefit premiums. It would also provide tax incentives to new and small businesses.

Medicaid Reform

Our plan would also implement Medicaid reforms that would establish national eligibility requirements and benefits to ensure that everyone below the federal poverty level (state adjusted) would receive uniform basic health benefits. The basic benefits would include: medical, hospital and emergency care, prescription drugs, rehabilitative and home health services, laboratory and x-ray services, family planning and, for children, early and periodic screening, diagnosis and treatment. Our plan also would increase recipients' access to Medicaid benefits by increasing Medicaid reimbursement to Medicare levels.

By limiting Medicaid coverage to basic health services for the economically needy, the existing hodge-podge of state programs will be supplanted with a more efficient, comprehensive program. Streamlining coverage in this manner will provide for improved access while maintaining the affordability of this government program.

Professional Liability Reform

Another vital component of Health Access America is its call for professional liability reform. A study reported in 1987 by the Health and Human Services Task Force on Medical Malpractice and Insurance confirmed that the threat of liability and the spiraling costs attributable to liability directly and significantly reduce access to health care. The Task Force reported decreased access attributable to liability in 26 states, with obstetrical and gynecological services the most likely to be affected, and low-income individuals the most likely to be deprived.

These findings are confirmed by a 1987 survey report of the American College of Obstetricians and Gynecologists which found that 12.4% of the physician respondents no longer practiced obstetrics, 12.9% decreased the number of deliveries and 27.1% decreased the volume of high-risk obstetrical care they provided. Even larger numbers of family practitioners have discontinued deliveries, and some states have large areas with no providers of obstetric care -- 57 counties in Georgia, 28 in Alabama and 19 in Colorado, to name a few.

Even where obstetrical services are available, they are often so costly that many individuals are denied access. In Florida, for example, liability insurance adds $1225 to the cost of delivering a baby. In New York and Arizona, the additional cost is $644 and $503, respectively. Given the greatly reduced access to obstetric care, it is not surprising that infant mortality, which had been decreasing since the 1970s, is now rising in some areas.

We urge this Subcommittee to recognize that the current professional liability system significantly and directly impairs access. Containing the escalating cost of medical liability offers an effective element to the solution to the access problem that would not entail federal expenditures.

At a minimum the following federal preemptive tort reforms should be adopted:

- cap damages for non-economic loss at $250,000 or less;
- require offset of collateral source benefits;
- provide for periodic payment of future damages;
- limit suspension of the statute of limitations for minors to no more than six years from birth; and
- require decreasing sliding scale regulation of attorney contingent fees.

We also support requiring a certificate of merit as a condition to filing a medical liability suit, and imposing minimum expert witness criteria. Finally, we believe that a fault-based administrative system, such as the one designed by the AMA in conjunction with medical specialty societies, may, in certain situations, provide a forum and process for dispute resolution far superior to the present system. We urge you to endorse demonstrations of such an alternative dispute mechanism.

Medicare Reform

Health Access America would reform Medicare by replacing the current "pay-as-you-go" system with an actuarially sound prefunded system. The program would be funded through individual and employer tax contributions during working years. At eligibility, individuals would receive a voucher for the purchase of private sector insurance meeting federal standards. This plan would substantially reduce government's funding and role in assuring access to health care for the senior population.

Long-Term Care

Our plan would broaden long-term care financing through tax incentives and an asset protection program, both of which would encourage private sector coverage.* Individuals between 100% and 200% of poverty would receive sliding scale subsidies to purchase long-term care insurance, and employer provided coverage would be entitled to the same tax treatment as health coverage. In addition, our plan would encourage family care giving by providing a tax deduction or credit.

Practice Parameters

Health Access America also calls for the development of practice parameters, i.e., professionally developed strategies for patient care developed to assist physicians in clinical decision making. The primary benefit of parameters is appropriate patient care. Secondary advantages include improved use of resources, reduced liability and better review

* The State of Connecticut is seeking a Medicaid waiver from Health and Human Services to demonstrate this concept.

criteria. The AMA, in conjunction with national medical specialty societies, the Consortium of Academic Medical Centers and the RAND Corporation, is currently working to facilitate the development of practice parameters as part of its long-standing efforts to foster high quality care and appropriate utilization.

Encouragement of Cost-Conscious Consumerism

Our plan would encourage cost-conscious choices by consumers in two ways -- it would alter the tax treatment of employee health care benefits to reward economical health care choices, and require insurers to inform consumers of the amount of insurance payment before a service is rendered.

Research, Prevention, Voluntary Care and Minimizing Administrative Red Tape

Health Access America would support increased federal funding for medical research and education and the National Institutes of Health, and would encourage health promotion and disease prevention activities. It would also encourage physicians to provide voluntary care, and reduce administrative costs by simplifying insurance paperwork requirements.

Conclusion

In closing, we recognize the frustration that exists among individuals, institutions, government and business with "problems" in health care. Some are so frustrated that they want to scrap the entire system and import foreign systems into the U.S. We think that would be a mistake.

It would be a mistake because the current system has so many strengths. It provides 87% of all Americans with health care services. It sets the world excellence standard in medical technology and quality of care. It incorporates freedom of choice and encourages competition in the health care market. These are precious attributes that we must not relinquish. Rather, we must retain them as the backbone of our system, and strengthen other aspects of the system to meet the needs of society.

Strengthening the system will not be inexpensive or easy. Good health care is not cheap. It is labor and technology intensive. As a nation, we must decide how to address the critical issues posed by the aging population and the many illnesses that plague this country. Blaming providers, insurers, government, business or patients is not the solution. Collaborative solutions that recognize the unique needs of each sector and America as a whole must be explored. The American Medical Association has put forth a proposal that attempts in good faith to meet the concerns of various sectors. We believe that it provides a firm foundation for national discussion.

5587p

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine (ASIM), representing physicians nationwide that are subspecialists in adult medical care, appreciates the opportunity to submit written comments for the record of the July 24, 1990 hearing of the Subcommittee on Health, Committee on Ways and Means regarding one of the most pressing problems facing this country: the inability of millions of Americans to have access to affordable medical care.

Let's make no mistake about it. America has two separate and unequal health care systems, one that provides access to a basic level of health insurance protection--and one that does not. Most Americans are fortunate to be under a system that allows them to obtain affordable health insurance through their employer. They can and do obtain the latest treatments and technology. They have access to regular, comprehensive medical care through their own personal physicians. And they know they can get good care, when they need it, without fear of becoming impoverished.

But more than 30 million Americans receive care, if and when they are able to obtain it at all, in a completely different world. For them, there is no health insurance protection. A major illness can mean personal bankruptcy. Even minor illnesses can represent an intolerably high expense. Delays in obtaining care are common and preventive care is virtually unknown. And, when they do get so sick that they can no longer go without professional care, treatment usually comes from chronically underfunded public clinics or hospital emergency rooms--or from physicians who donate their services on a charity basis.

Many other Americans--the underinsured--have insurance coverage that provides inadequate protection against the costs of a catastrophic illness. Even those Americans with good health insurance are at risk of joining the ranks of the uninsured. Unemployment or an illness followed by a change in jobs can lead to loss of coverage.

ASIM Recommendations for Ending Separate and Unequal Health Care

ASIM believes that it is time to put an end to separate and unequal health care. Our recommendations, which are fully detailed in the attached paper titled "Ending Separate and Unequal Health Care," closely parallel the Pepper Commission's recommendations. ASIM supports requiring all employers to provide health insurance to their employees. We advocate reforming the insurance marketplace to reduce premium costs, avoid preferential skimming of healthy subscribers, spread the cost burden more equitably, and to eliminate existing barriers to coverage. We believe that federal subsidies and tax breaks should be provided to small businesses to make insurance more affordable and available.

We believe that Medicaid should be converted from a welfare program to one that provides adequate, consistent coverage to any American, regardless of income or locale, who cannot obtain coverage through an employer. Simultaneously, increases in physician reimbursement under Medicaid, which most often does not even reimburse physicians' overhead costs, are needed to improve access to primary care for our poorer citizens.

As recommended by the Health Policy Agenda for the American People, comprehensive health care reform is necessary. Expansions in Medicaid eligibility without mandating employer coverage would significantly increase the price tag of Medicaid reform if businesses that provide insurance drop that coverage because their lower-income employees now qualify for Medicaid. The preferred approach--a combination of an employer mandate and Medicaid reform--would reduce the cost of expanded Medicaid eligibility because more employers would be required to provide coverage to the working poor, who without employer coverage, would qualify for Medicaid.

Some have advocated that we scrap the current system of private/public insurance and adopt a single-payer system. Although the specifics of single-payer proposals vary, they have one common element--the creation of a national insurance program primarily funded by the federal government. ASIM strongly opposes any effort to substitute the current pluralistic system of insurance with a single-payer approach. The current private system provides coverage to 80 percent of employees and their dependents. Mandating employer coverage would provide insurance to all but one-fifth of the uninsured, with the remaining uninsured getting coverage through the public program.

Under a single-payer approach Americans health care would be at greater risk to competing budget priorities and restricted access to needed services. Multiple funding sources, as ASIM proposes, protect the public from too much power being concentrated in any single-payer. Concentrating the financing of health care in the hands of one payer also eliminates choices for patients as well as employers. Under the current pluralistic system of insurance, if employers and patients do not like the service they receive from an insurer, the benefits under the plan are inadequate or the managed care restrictions on the plan are unacceptable they can simply

purchase coverage from another plan. If the government-financed program is the only choice available, employers and patients have no choice to change coverage to another financing source.

ASIM believes that Americans want the freedom to choose their insurance plan, their physician and their hospital. A recent Gallup Poll survey reports that 83 percent of Americans surveyed would rather pay more and have a personal physician that they have chosen than pay less and have a physician assigned to them by government or a private clinic. Even if a single-payer system guaranteed "free choice of physicians", the freedom of patients and physicians to mutually decide the best and most appropriate care would inevitably be undermined and limited by the enormous monopoly power that a single-payer system would give to government to set limits on care available to patients.

ASIM believes that building on the current health care insurance system is what the American people want. A recent article published in the New England Journal of Medicine (July 19, 1990) by Robert Blendon, ScD, of Harvard University, supports this claim. Blendon concluded, based on survey data from 1938 to 1990, that Americans would not favor a major overhaul in the health care system that places emphasis on an exclusively public or private financing program. Rather, Americans overwhelmingly prefer a proposal for universal health care that builds on the strengths of the current public/private system of insurance.

ASIM Recommendations on Cost-Containment

When mandating employers to provide insurance to their employees and their dependents, we must institute effective cost containment measures to reduce the costs of inappropriate medical care and administrative waste in the system thereby making the health care delivery system more efficient and cost-effective. The development of practice guidelines--which would eliminate inappropriate medical care--insurance reforms, reductions in the administrative costs of insurance, medical liability reform and adequate levels of patient cost-sharing should be instituted to reduce the costs of care. Additionally, ASIM recognizes that we can and must take other steps to contain health care costs.

In the past year there has been widespread attention given to the state of Oregon in its efforts to prioritize health care services based on cost and effectiveness for purposes who determining coverage under Medicaid. In our opinion, society is not prepared to explicitly ration health care services at this time. The Robert Blendon study, referenced above, concluded that only one in five Americans would support rationing of services. Furthermore, we have not yet made every effort to reduce the inefficiencies in the current health care system. For these reasons, ASIM strongly prefers continued efforts to make the health care system as efficient as possible over a system of explicit prioritizing of health services for purposes of determining coverage.

Despite these efforts, however, ASIM recognizes that costs may continue to escalate beyond what society is willing and able to pay for and a system of prioritizing services may need to be considered. Under these circumstances, ASIM believes that such priorities should be based on scientific data, outcomes research and a reflection of society's values and expertise of the profession. Additionally, a system for re-evaluating priorities would be necessary.

ASIM believes that selective contracting for certain high-cost non-emergency procedures may be an appropriate means of containing costs provided certain protections are built in. To illustrate, a 1987 study conducted by the Office of Inspector General concluded that over $192 million can be saved, with improved quality, if Medicare implemented a selective contracting program for coronary artery bypass surgeries. We believe this particular form of selective contracting has merit because there is sufficient data to indicate that selective contracting for narrowly defined, high-cost, non-emergency procedures, improves quality and outcome while reducing costs. However, ASIM believes certain protections must be instituted.

Specifically, travel costs for the patient and where appropriate family members and distance from the contracted site, should not impede access to services. Additionally, patients should not be restricted from, or penalized for opting out of the contracted site in medical emergencies. Finally, consumers should be allowed to select a health care plan that does not require them to obtain certain services at contracted sites. This plan may cost more than the plan which requires certain procedures to be obtained from designated facilities.

ASIM believes contracts should not be automatically awarded to the lowest bidder. To ensure quality of care, the payer must consider quality in terms of mortality rates, lengths of stay, morbidity, willingness to follow accepted practice guidelines, the existence of adequate self-

assessment and peer review, the achievement of a critical volume of procedures in addition to costs.

ASIM supports the use of practice guidelines as a means of reforming the Medicare utilization review system and application of these reforms to other third-party payers and Medicaid. ASIM believes that when payment for services is tied to practice guidelines, physicians will appropriately change their behavior. For this reason, ASIM continues to support the concept of linking practice guidelines based on outcomes research to payment for services. ASIM believes that adherence to practice guidelines should result in payment to the physician without excessive demands for documentation and appeals in order to get claims paid. These demands only add to the overall administrative costs of health care. However, when guidelines designate a service or procedure as clearly inappropriate, the burden of proof for the claim to be paid should fall on the physician.

Without question, the high cost of technology is largely responsible for increases in health care costs. ASIM supports appropriate efforts to analyze the costs and benefits of medical technology. However, these efforts should not explicitly limit the development and diffusion of new and improved technologies. Advances in technology obviously improve the quality of life for all Americans. In concert with this, ASIM recognizes that efforts to educate the public and physicians about the effectiveness of technology, as determined by appropriate professional bodies, are necessary to relieve patient and physician demand for technologies of unproved benefit.

There is much debate concerning the application of volume performance standards (VPS) to Medicaid and other third-party payers in an effort to contain health care expenditures. The question of whether Medicare VPS will be effective in reducing volume or services or simply be used to inappropriately limit physician fees is still largely unanswered. For this reason, ASIM opposes the application of VPS to other payers at this time. However, should VPS prove effective in reducing volume in Medicare services and be applied to other private third-party payers, savings should be passed on to employers and employees through lower premiums and to physicians as improved reimbursement, not passed on as profit to the private payer.

ASIM Recommendations on Financing Expanded Access to Care

Despite growing support for expanding access to care for the uninsured, there is both a lack of consensus and recommendations on the question of how to finance universal access to care and who pays. For these reasons, ASIM is committed to identifying revenue sources to help pay for expanded access to care. While increasing pressures to reduce the size of the federal budget have resulted in across the board cuts of many federal programs over the years, we believe that additional savings in various programs can be achieved and have merit. As a part of our financing plan, ASIM supports the use of budget savings in other federal programs to help finance expanded access to care for the uninsured. Additionally, ASIM believes that the existing funds available in the health care delivery system can be used more effectively and efficiently–primarily by reducing inappropriate medical care and excessive administrative costs–to help finance access to care.

Beyond these key features, we have developed a specific financing plan that, if enacted, would provide access to care for all uninsured Americans. Specifically, ASIM has endorsed four criteria that should be used in identifying additional revenues for providing basic health care to the uninsured. We believe that any tax increase ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens, and revenues should grow fast enough to keep up with the needs of financing care for the uninsured. Since all ages would benefit, persons of all ages should contribute. Finally, any tax option should generate revenues that have a positive impact on the general health of all Americans. While ASIM supports efforts to target budget savings in other federal programs toward expanding access to care, ASIM understands that, despite these efforts, an increase in the personal income tax may be necessary to finance access to care for the uninsured and these criteria should be considered.

Clearly, the American public is not prepared to support an increase in the personal income tax at this time. Blendon concluded from public opinion surveys that "any new program for universal access should rely on taxes other than the progressive income tax. Most Americans are unwilling to pay even a modest increase ($200 per year) in their taxes to make a universal health care plan a reality." For this reason, we believe that efforts must focus first on identifying resources already in the health care system, budget savings in other federal programs and increases in other taxes, e.g. tax caps and federal excise taxes on alcohol and tobacco.

ASIM believes that a combination of increases in the federal excise taxes on alcohol and tobacco and a reasonable tax cap on the amount of health insurance premiums an employer can deduct as a business expense–thereby becoming taxable income to the employee–would provide

sufficient funding to expand access to health care for the uninsured. Polls show that these taxes are considered more favorably by Congress and the public. The Pepper Commission estimates that a total of $23.4 billion would be required to fund the public portion of the access package. A February 1989 Congressional Budget Office (CBO) report estimates that a $3,000 tax cap alone would generate $20.5 billion by 1994. A 16 cent increase in the cigarette tax would increase federal revenues by $2.8 billion and an increase in the alcohol tax (56 cents on a bottle of liquor, 65 cents on a six pack of beer and 67 cents on wine) would raise $7.2 billion in revenues in 1991 according to CBO. From these taxes alone, revenues would increase $30.5 billion, enough to fund the public portion of ASIM's recommendations on access to care. ASIM also supports raising revenues from persons who engage in activities that lead to higher health care spending through means such as levying surcharges on DWI and drug conviction fines to help finance access to care for the uninsured.

Expanding access to care by building on the strengths of the current system unquestionably will cost money. But the human and economic costs of not addressing the problem are far greater. We can no longer afford to take a "wait a minute" attitude and study the problem further, or expect someone else to pay the cost.

We know what the solutions are. We know that a combination of expanding employer-based health insurance and providing adequate public funding will work. We also know that if enough people want change, this country has the resources to make that change possible. And we know that the cost burden must be shared equally, so that no one segment of society is asked to pay the entire bill.

The time has come for Congress to move forward and enact comprehensive legislation. ASIM and 21 other medical organizations have formed a coalition to press for enactment this year of comprehensive access legislation, based on principles that are consistent with the Pepper Commission plan. Physicians stand ready to do everything we can to get such legislation enacted without further delay. We call upon business, labor, the administration, hospitals and consumers to do the same.

Millions of uninsured Americans are effectively being held hostage while those of us in Washington argue over whether now is the time to act. But the answer is simple. Just ask my patients. Even more importantly, ask those who never get to see me because they lack health insurance and are too proud to ask for charity. They all say the same thing–they want action–not next year or the year after, but now.

In conclusion, ASIM believes that an agenda for assuring access to care for all Americans, including the enactment of legislation modeling ASIM's recommendations, to expand health insurance coverage to all Americans, can be achieved. We stand ready to assist the Congress in its deliberations on this critical issue having impact on all Americans.

ASIM POLICY ON FINANCING ACCESS TO CARE FOR THE UNINSURED

1. ASIM supports the use of budget savings achieved in other federal programs to help finance expanded access to care.

2. ASIM believes that the existing funds available in the health care system today can be used more effectively and efficiently to eliminate unnecessary medical services and excessive administrative costs in order to free up money for expanding access to care for the uninsured.

3. ASIM supports the following criteria for raising additional revenues for basic health care for the uninsured:

    a. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens (current income tax structure). That is, families with higher incomes contribute a greater share of their incomes than is required of families with lower incomes.

    b. Since all ages would benefit, persons of all ages should contribute to financing access to care for the uninsured.

    c. Revenues chosen should grow fast enough to keep up with the needs of financing care for the uninsured so that new sources of revenue will not need to be enacted over time.

    d. Any financing option should generate revenues and have a positive impact on the general health of all Americans.

4. ASIM supports placing a reasonable limit on the amount of health insurance premiums paid by an employer that can be deducted as a business expense. Amounts paid in excess of this limit would be taxable income to the employee. The Congressional Budget Office (CBO) estimates that a $3,000 tax cap alone would generate $20.5 billion by 1994.

5. ASIM supports increases in federal excise taxes on alcohol and tobacco to finance health care for the uninsured. According to CBO estimates, a 16 cent increase in the cigarette tax would increase federal revenues by $2.8 billion, and an increase in the alcohol tax (56 cents on liquor, 65 cents on beer and 67 cents on wine) would raise $7.2 billion in revenues in 1991. Additionally, ASIM supports surcharges on DWI offenders and drug convictions to help finance care for the uninsured.

Based on estimates of the Pepper Commission, ASIM's recommendations for expanding access to care for the uninsured would cost approximately $23.4 billion in new federal revenues. Placing a limit on the amount of health insurance premiums paid by the employer that can be deducted as a business expense–thereby becoming taxable income to the employee–and increases in the federal excise taxes on alcohol and tobacco would increase federal revenues $30.5 billion which would adequately fund ASIM's recommendations.

ASIM POLICY ON HEALTH CARE COST-CONTAINMENT

1. ASIM supports funding for outcomes research and the development of practice guidelines, appropriate copayments and deductibles, medical liability reform, the elimination of administrative inefficiencies and physician and patient hassles for payment of claims in the public and private insurance markets and the implementation of physician payment reform.

2. ASIM strongly prefers continued efforts to make the health care system as efficient as possible over a system of explicit prioritizing of health services for purposes of determining coverage. Only after all efforts have been made to develop an efficient health care system and, despite such efforts, costs continue to increase beyond what society is willing or able to pay for, should a system of prioritizing services be considered. Such priorities must be determined based on scientific data, outcomes research and, a reflection of society's values and expertise of the profession. Furthermore, a system for re-evaluating priorities is necessary.

3. ASIM believes that selective contracting for certain high-cost, non-emergency procedures may be an appropriate means of containing costs provided certain protections are built in, including:

    a. Travel costs for the patient, as well as family members when appropriate, and distance from the contracted site should not impede access to services. All travel costs should be reimbursed by the payer.

    b. Consumers should be able to select a health care plan that does not require them to obtain certain services at contracted sites. This plan may require a higher premium or higher out-of-pocket expenses than the plan which requires certain procedures to be obtained at designated facilities.

    c. Contracts should not automatically be awarded to the lowest bidder. The payer should consider quality of care in terms of mortality rates, lengths of stay, morbidity, willingness to follow accepted practice guidelines, the existence of adequate self-assessment and peer review programs, and critical volume of procedures in addition to costs.

    d. Patients should not be restricted from, or penalized for opting out of the contracted site in cases requiring immediate medical attention.

4. ASIM supports appropriate efforts to analyze the costs and benefits of medical technology but opposes the use of technology assessment explicitly to limit the development and diffusion of new technology.

5. ASIM supports the dissemination of useful information about the effectiveness of technology, as determined by appropriate professional bodies, adequate funding for research on the effectiveness and outcomes of technology, and public education to relieve patient and physician demand for technologies of unproved benefit.

6. ASIM opposes the application of volume performance standards (VPS) to Medicaid and other third-party payers until sufficient evidence is developed demonstrating the effectiveness of VPS in appropriately controlling volume of services under Medicare. Should VPS be applied to other private third-party payers and found to be successful in controlling volume of services, the savings should be passed on to employers and employees through lower premiums and to physicians as improved reimbursement, not passed on as profit to the payer.

7. ASIM supports the use of practice guidelines as a means of reforming the Medicare utilization review system and the application of these reforms to other private third-party payers and Medicaid. ASIM supports the concept of linking practice guidelines based on outcomes research to payment for services. ASIM believes adherence to practice guidelines should result in payment to the physician without excessive demands for documentation and appeals in order to get claims paid. However, when guidelines designate a service or procedure as clearly inappropriate, the burden of proof for the claim to be paid should fall on the physician.

8. ASIM supports varying copayments by type of service, with reasonable copayments on primary care services, diagnostic and surgical services based on the ability to pay.

9. ASIM supports further study of ways of reimbursing physicians based on quality of services provided as opposed to quantity of services performed.

33-773 (72)